Arizona Health Care Cost Containment System Administration (AHCCCSA)

AHCCCS

2005–2006 External Quality Review Technical Report *for* Acute Care Plans

June 2007

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HSAG HEALTH SERVICES ADVISORY GROUP

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Introduction

Health Services Advisory Group, Inc. (HSAG) serves as an external quality review organization (EQRO) for the Arizona Health Care Cost Containment System (AHCCCS). This annual technical report complies with 42 Code of Federal Regulations (CFR) 438.364. The report is for contract year (CY) 2005–2006 and describes how the data from activities conducted in accordance with 42 CFR 438.358 were aggregated and analyzed. The report also explains the methodologies used to draw conclusions about the quality and timeliness of and access to care furnished by the following health plans: Arizona Physicians IPA, Care1st Healthplan of Arizona, Health Choice Arizona, Maricopa Health Plan, Mercy Care Plan, Phoenix Health Plan, Pima Health System, University Family Care, and the Arizona Department of Economic Security Comprehensive Medical and Dental Program (DES/CMDP). The report includes the following information for each activity:

i. Objectives

ii. Technical methods of data collection and analysis

iii. Description of data obtained

iv. Conclusions drawn from the data

v. The extent to which the State provided the necessary information to create this report while safeguarding the identities of patients

Also included in this report is an assessment of each health plan's strengths and opportunities for improvement with respect to the quality and timeliness of and access to health care services furnished to Medicaid members, with related recommendations when applicable, to improve the quality of health care services each health plan offers. Comparisons of performance across health plans based on quality, timeliness, and access are also highlighted. The requirement to assess each plan on the extent to which it has addressed recommendations for quality improvement made as a result of the previous year's review is accomplished through the ongoing system of requiring corrective action plans (CAPs) that is administered and monitored by AHCCCS. Fundamental to this system, the health plans must propose formal CAPs and have them accepted by AHCCCS for deficiencies in the plans' performance that were identified as part of the AHCCCS ongoing monitoring and formal annual operational and financial review (OFR) processes.

The technical methods of data collection and analysis are presented first, including the EQRO's methods in preparing this report and the methods used by AHCCCS and the health plans as they have been mandated by AHCCCS, and which do not differ across health plans. The external quality review (EQR) assessment of the data obtained and the conclusions drawn from these data form the basis for the findings presented in each section, both separately for each health plan and comparatively across health plans. In the final section, the report presents the State with a statewide summary of findings and, as applicable, with recommendations for continued quality improvement beyond the recommendations found in the separate sections addressing each of the mandated activities.

AHCCCS's Unique Approach

Each state that contracts with managed care organizations (MCOs, or health plans) must ensure that it has a qualified EQRO perform an annual external quality review (EQR) for each contracting health plan. The state must ensure that the EQRO has sufficient information to perform the review for each of the EQR-related activities described in 42 CFR 438.358. In addition, the information provided to the EQRO must be obtained through methods consistent with the protocols established under 42 CFR 438.352. In general, the majority of state Medicaid agencies nationwide competitively bid the mandatory activities required by the federal government in seeking competent EQROs to perform these services. AHCCCS, however, is unique not only as a national model program for managed health care, but also for the approach it uses for EQR activities. AHCCCS has developed its own expertise and models for addressing the mandatory activities, including conducting it's own reviews to determine health plan compliance with financial and operational standards, collecting health plan encounter and other data and using the data to directly calculate and measure the health plan performance for the AHCCCS performance measures and required PIPs, and conducted overall validation of encounter data according to industry standards.

AHCCCS reviewed the relevant information, data, and procedures from these activities to determine the extent to which they are accurate, reliable, free from bias, and in accordance with industry standards for data collection and analysis. To meet the mandatory requirements for information that must be produced by an EQRO, AHCCCS contracts with HSAG to provide the external quality review technical report. HSAG is an EQRO that meets the competence and independence requirements set forth in 42 CFR 438.354.

HSAG Methodology for Data Acquisition and Reporting

On January 19, 2007, AHCCCS and HSAG met to discuss the EQR technical report contract and AHCCCS' expectations for the technical report of findings from the mandatory activities. AHCCCS provided HSAG with comprehensive documentation of the AHCCCS processes and results obtained related to each of the three mandated activities (i.e., compliance with select contract and federal requirements, PIPs, and performance measures). HSAG reviewed the documentation provided by AHCCCS and developed a summary tool to crosswalk the data provided related to the plans' performance with respect to each of the mandated activities. Following a preliminary review of the documentation and to ensure that HSAG was using complete and accurate information in preparing the technical report, HSAG developed and provided to AHCCCS a list of questions about or requests for clarification related to the documentation and data provided. AHCCCS responded promptly to HSAG's questions and requests for clarification. As needed throughout the preparation of this report, HSAG communicated with AHCCCS to clarify any remaining questions regarding the data and information and provided monthly written reports to AHCCCS that described HSAG's progress in completing each of the major activities critical to preparation of the technical report. A first draft of this technical report was provided to AHCCCS for its review on April 27, 2007.

Compliance with Standards (Operational and Financial Review)

Objectives for Review of Operational and Financial Review (OFR) Standards

HSAG designed a summary tool to organize and represent the information presented in the nine individual health plan reports documenting the plans' performance in complying with the operational and financial standards, and to facilitate a comparison of the health plans' performance. The summary tool focused on the objectives of this analysis, which were to:

1. Determine each health plan's compliance with standards established by the State to comply with the requirements of the AHCCCS contract and 42 CFR 438.204(g).
2. Provide data from the review of each plan's compliance with the standards that would allow conclusions to be drawn as to the quality and timeliness of and access to care furnished by the health plans.
3. Aggregate and assess CAPs to provide an overall evaluation.

Methodology for Review of Operational and Financial Review Standards

The AHCCCS mission is: "Reaching across Arizona to provide comprehensive, quality health care for those in need." In support of that mission, AHCCCS provided health plans with: (1) a detailed description of the contract requirements and expectations for each of the standards that AHCCCS would review, and (2) a list of documents and information that was to be available to AHCCCS for its review during the OFR process.

AHCCCS reviewed the operational and financial performance of health plans throughout the year. The Agency Review Team, which was composed of staff from the Division of Health Care Management, the Office of Legal Assistance, the Division of Business and Finance, and the Office of Program Integrity, performed on-site reviews to interview and observe the operations of health plan personnel and to review documentation. The AHCCCS OFR encompassed the following areas:

- Delegated Agreements
- Delivery System
- Grievance System
- Medical Management
- Quality Management
- Maternal and Child Health
- Claims System
- Reinsurance
- Third Party Liability

Reviews generally required three to five days, depending on the extent of the review and the location of the health plan. The OFRs allowed AHCCCS to:

- Determine the extent to which each health plan's performance met AHCCCS' contractual requirements, AHCCCS policies, and the Arizona Administrative Code.
- Increase its knowledge of each health plan's operational and financial procedures.
- Provide technical assistance and identify areas for improvement and areas of noteworthy performance and accomplishment.
- Review progress in implementing the recommendations made during prior OFRs.
- Determine each health plan's compliance with its own policies and procedures and evaluate their effectiveness.
- Perform health plan oversight as required by the Centers for Medicare & Medicaid Services (CMS) in accordance with the AHCCCS 1115 waiver.

AHCCCS prepared an annual report of review findings and sent it to each health plan. In the report, each standard and substandard was individually listed with the applicable performance designation based on AHCCCS' review findings and assessment of the degree to which the health plan was in compliance with the standards. Full Compliance was 90 to 100 percent compliant, Substantial Compliance was 75 to 89 percent compliant, Partial Compliance was 50 to 74 percent compliant, and Non-Compliance was 0 to 49 percent compliant. Not applicable was N/A.

The reports sent to the health plans also included, when applicable, any AHCCCS recommendations, which were stated as:

- *The health plan must*…. This statement indicates a critical noncompliant area that must be corrected as soon as possible to be in compliance with the AHCCCS contract.
- *The health plan should*…. This statement indicates a noncompliant area that must be corrected to be in compliance with the AHCCCS contract but is not critical to the everyday operation of the health plan.
- *The health plan should consider*…. This statement is a suggestion by the review team to improve the operations of the health plan but is not directly related to contract compliance.

Each health plan was required to submit a response to each of the first two types of recommendations with a proposed CAP. AHCCCS reviewed each plan's CAPs and approved the CAPs when satisfied that the initial or, as applicable, revised CAPs when requested by AHCCCS, were sufficient to address the deficiencies and to bring the plan back into compliance with the applicable requirements. Health plans have the right to challenge AHCCCS' findings.

Validation of Performance Measures

Objectives for Review of Validation of Performance Measures

In its objectives for the review of validation of performance measures, AHCCCS:

1. Provided each health plan with the necessary information on State-required performance measures.
2. Utilized the health plan encounter data submitted to AHCCCS to calculate the performance measure rates.
3. Conducted overall validation of encounter data according to industry standards.

Methodology for Review of Validation of Performance Measures

AHCCCS calculated the rates to evaluate preventive health care quality following the Health Plan Employer Data and Information Set (HEDIS®)[2-1] methodology. HEDIS was developed and is maintained by the National Committee for Quality Assurance (NCQA) and is a widely used and well-accepted set of performance measures for health care providers.

To select the members included in the annual analysis, AHCCCS used HEDIS criteria (e.g., members must have been continuously enrolled with the health plan for a specified minimum period of time). AHCCCS has also adopted the NCQA's methodology of rotating measurements to produce a more comprehensive annual report of preventive health care services over time without having to collect the entire measure set each year. This rotating schedule alternated measures on a biennial basis and made an intervention year possible for quality improvement efforts. It also gave each health plan the opportunity to focus activities on improving specific measures that AHCCCS had identified in its prior-year annual reports as requiring attention. Notwithstanding this general approach, rates for the Children's Access to Primary Care Practitioners (PCPs) measure and the Adult's Access to Preventive/Ambulatory Health Services measure were calculated annually.

Except for the measure, Timeliness of Prenatal Care, AHCCCS has changed the process by which data are collected for the performance measures by using a data warehouse. Previous to the current data collection, AHCCCS had been collecting data on services and recipients directly from the Prepaid Medicaid Management Information System (PMMIS). In addition, AHCCCS adjusts the HEDIS 2005 methodology for this measurement by using a contract year as the measurement period instead of a calendar year.

In previously reported measurements, AHCCCS collected data directly from PMMIS using HEDIS specifications as a guide, but with additional deviations. With the implementation of the data warehouse in CYE 2006, AHCCCS now utilizes pure HEDIS, with the exception of the measurement period (calendar year vs. contract year). Nonetheless, Timeliness of Prenatal Care has been collected directly from PMMIS using the same process as in the previous two years, according to HEDIS specifications.

[2-1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

To create valid comparisons with data collected through the new process, AHCCCS used the data warehouse to recalculate rates for the previous year, i.e., contract year ending (CYE) 2004, which also are reported in this document. Except for Timeliness of Prenatal Care, the rates reported in this publication cannot be directly compared with rates in the previous AHCCCS report on acute care measures, published in November 2005, due to the differences in methodologies. Moving forward, however, the rates will be comparable.

AHCCCS also conducted data validation studies to evaluate the completeness, accuracy, and timeliness of encounter data. In CYE 2006 (October 1, 2005, through September 30, 2006), for the eight managed care plans, and in CYE 2006, for DES/CMDP, AHCCCS conducted an encounter data validation study on CYE 2004 (October 1, 2003, through September 30, 2004) data. Based on the most recent data validation study by AHCCCS, approximately 90 percent of all encounters for professional services were complete when compared with corresponding medical records. Approximately 85 percent were fully accurate, compared with services documented in members' medical records.[2-2]

Assessment of Performance Improvement Projects (PIPs)

Objectives for Review of Performance Improvement Projects

In its objectives for the assessment of PIPs, AHCCCS:

1. Ensured that each health plan had an ongoing performance improvement program of projects that focused on clinical and nonclinical areas for the services it furnished to its members.
2. Ensured that each health plan measured performance using objective and quantifiable quality indicators.
3. Ensured that each health plan implemented systemwide interventions to achieve improvement in quality.
4. Evaluated the effectiveness of each health plan's interventions.
5. Ensured that each health plan planned and initiated activities to increase or sustain its improvement.
6. Ensured that each health plan reported collected data/information to the State for each project in a reasonable period to allow timely information on the status of PIPs.
7. Calculated and, for the Diabetes PIP, validated the PIP results from the health plan data/information.
8. Annually reviewed the impact and effectiveness of each health plan's performance improvement program.
9. Required that each health plan have an ongoing process to evaluate the impact and effectiveness of its performance improvement program.

[2-2] Quality Management Performance Measures for Acute Care Contractors, Arizona Health Care Cost Containment System, Measurement Period Ending September 30, 2005, Prepared by the Division of Health Care Management, December 2006.

Methodology for Review of Performance Improvement Projects

AHCCCS required that health plans have an ongoing program of PIPs that focused on clinical and nonclinical areas. These projects involved measuring performance by using objective and quantifiable quality indicators, implementing system interventions to achieve performance improvements, evaluating the effectiveness of the interventions, and planning and initiating activities to increase or sustain improvements.

The PIPs reviewed for this external quality review technical report were Adult Management of Diabetes (not required of DES/CMDP) and Children's Dental Health. The populations for the two PIPs reviewed were selected according to HEDIS criteria.

Throughout the process, AHCCCS maintained confidentiality in compliance with Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements. The files were maintained on a secure, password-protected computer. Only AHCCCS employees who analyzed the data had access to the database, and all employees were required to sign confidentiality agreements. Only the minimum amount of necessary information to complete the project was collected. Upon completion of each study, all information was removed from the AHCCCS computer and placed on a compact disc to be stored in a secure location.

When the data were collected and reported to AHCCCS by the health plans, AHCCCS then calculated the PIP results and reviewed and assessed health plan performance using the criteria found in *Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities* (Department of Health and Human Services, Centers for Medicare & Medicaid Services, Final Protocol, Version 1.0, May 1, 2002). This process involved 10 distinct steps as delineated in the CMS protocol:

1. Review the selected study topic(s)
2. Review the study question(s)
3. Review selected study indicator(s)
4. Review the identified study population(s)
5. Review sampling methods (if sampling was used)
6. Review the plan's data collection procedures
7. Assess the plan's improvement strategies
8. Review the data analysis and the interpretation of the study's results
9. Assess the likelihood that reported improvement is real improvement
10. Assess whether the plan has sustained its documented improvement

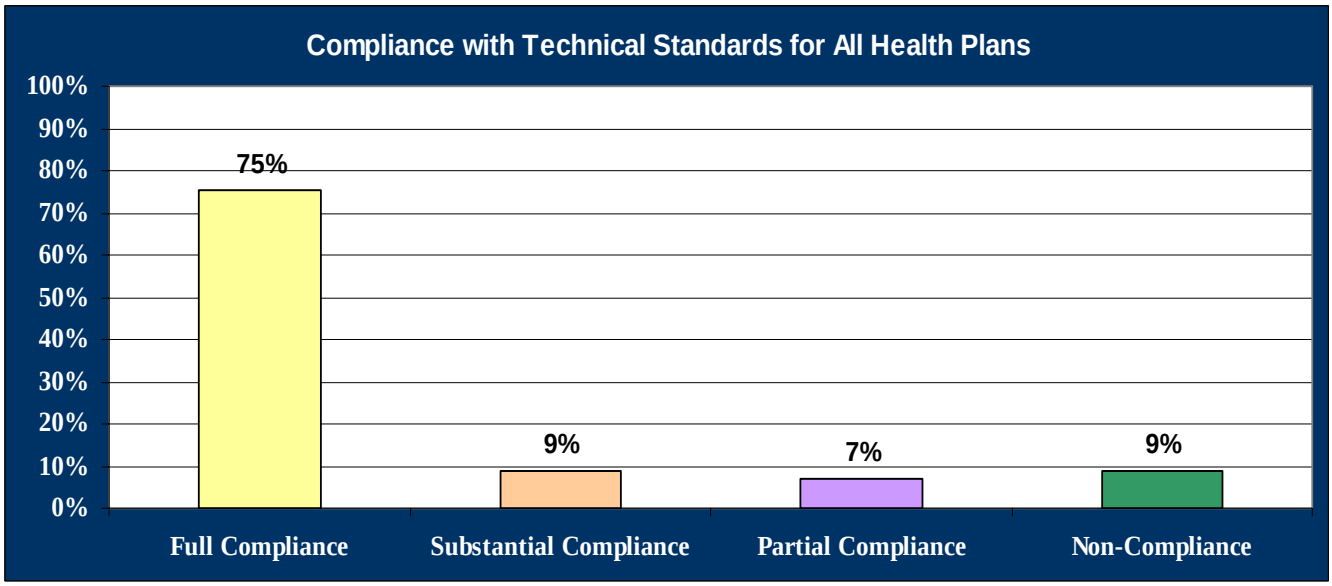
The methodology for evaluating each of the 10 steps is covered in detail in the CMS protocol, including acceptable and not acceptable examples of each step. When completed, AHCCCS forwarded its assessment of the PIPs to each health plan. Each health plan had the opportunity to comment on the results and any required actions included in the evaluation report. AHCCCS provided the overall evaluation reports and plan-specific results to HSAG for its review and inclusion in this external quality review technical report.

Overall Findings for All Health Plans

Compliance with Standards (Operational and Financial Review)

Before presenting the plan-specific findings, a frame of reference is provided by showing the aggregate results for the State. Figure 3-1 shows that across the State's health plans, three-quarters of the technical standards were in Full Compliance with all the requirements. For the remaining technical standards (i.e., standards with performance not in Full Compliance) performance scores were about equally divided between Substantial, Partial, and Non-Compliance results, at 9 percent, 7 percent, and 9 percent, respectively.[3-1]

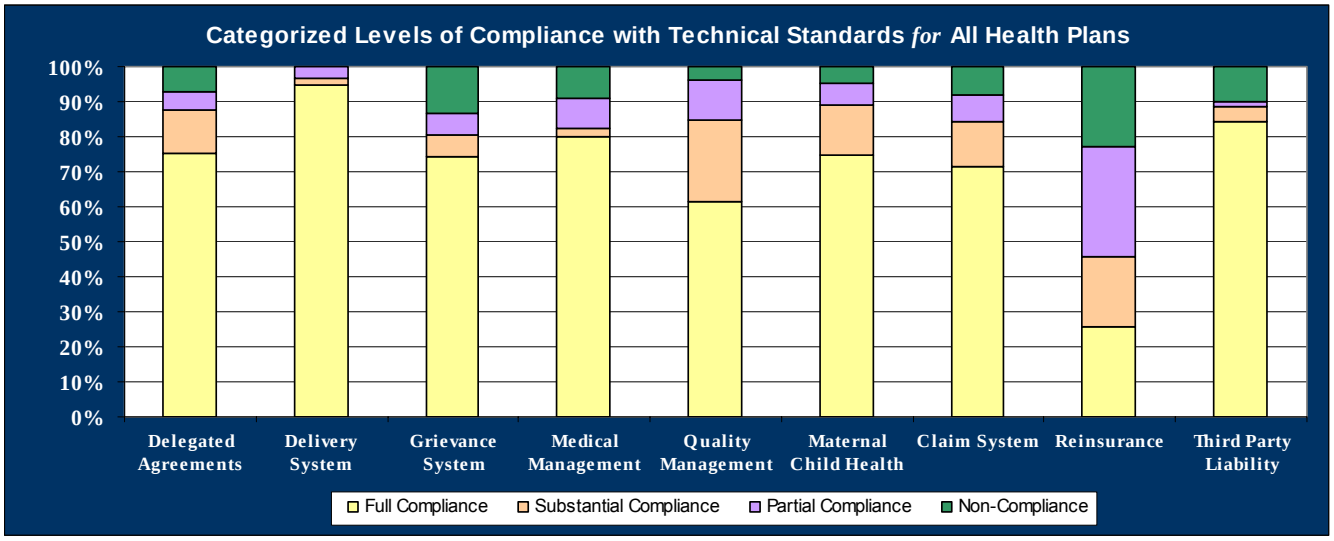
Figure 3-1—Compliance with Technical Standards *for* All Health Plans



[3-1] The color-coding for the bars in Figure 3-1 is used consistently for all graphs of compliance with technical standards, including the colors used for stacked-bar graphs, such as Figure 3-2.

Figure 3-2 shows results for the individual categories of the technical standards, providing the details needed to interpret which areas have greater compliance than others and, conversely, which areas show greater opportunities for improvement. Three overall findings can be seen in this graph. First, performance for Delivery System is in Full Compliance for 95 percent of the technical standards reviewed across all health plans. Although some health plans might not be in Full Compliance for this category, the plans have performed well, overall. Second, performance for Reinsurance shows the greatest opportunity for improvement across all health plans, with only 26 percent of the technical standards reviewed showing Full Compliance with requirements. This finding suggests that the majority of health plans need to improve their compliance with the requirements for this category of standards. Third, the remaining categories of technical standards show sufficiently mixed results to require plan-specific findings to identify individual strengths and opportunities for improvement. These mixed results contrast with the more uniform results seen for Delivery System (as a statewide strength) and for Reinsurance (reflecting a statewide opportunity for improvement).

Figure 3-2—Categorized Levels of Compliance with Technical Standards *for* All Health Plans



Compliance with Standards—CAPs

Table 3-1 presents each of the categories of technical standards reviewed, the number of CAPs required, each category's percentage of all CAPs, the number of technical standards in each category, and the percentage of technical standards with a required CAP for each category.

Table 3-1—CAP Overview *for* All Plans

Categories of Technical Standards	Number of CAPs	Percent of Total CAPs	Total Number of Standards Across Plans	CAPs as Percent of Standards
Delegated Agreements	12	6%	57	21%
Delivery System	6	3%	94	6%
Grievance System	57	30%	198	29%
Medical Management	9	5%	45	20%
Quality Management	11	6%	26	42%
Maternal and Child Health	19	10%	63	30%
Claims System	35	18%	126	28%
Reinsurance	26	14%	35	74%
Third Party Liability	15	8%	89	17%
Total	**190**	**100%**	**733**	**26%**

The table presents two types of findings: (1) categories with a high/low number of required CAPs proportionate to the total number of overall CAPs, and (2) categories with a high/low percentage of technical standards requiring a CAP. The first of these types of findings shows Grievance System with the highest proportion overall, at 30 percent of the total number of CAPs. Delivery System shows the lowest proportion, at 3 percent. As a percentage of the number of technical standards within each category, Reinsurance was at 74 percent CAPs compared with Delivery System at 6 percent. Both of these findings are consistent with the findings from Figure 3-2. Finally, 26 percent of all the technical standards reviewed across all health plans required a CAP.[3-2]

[3-2] The currently reviewed technical standards are sufficiently different from the technical standards reviewed the previous year to render a year-to-year comparison inappropriate.

Performance Measure Review

Table 3-2 presents the mean rates across the nine health plans during the two most recent measurement periods for each of the performance measures. Where there were no data for some of the measures, the statewide mean was calculated from the available information.

Table 3-2—Performance Measurement Programs *for* All Plans

Performance Measure	Previous Measurement Period[1]	Actual Performance for Oct. 1, 2004, to Sept. 30, 2005	Minimum AHCCCS Performance Standard
Children's Access to PCPs[2]	76.9%	77.9%*	79%
Adult's Access to Preventive/Ambulatory Health Services[2]	78.6%	79.2%*	80%
Breast Cancer Screening[2,3]	48.3%	48.8%	57%
Cervical Cancer Screening[2,4]	52.5%	54.4%*	61%
Timeliness of Prenatal Care[4]	**67.4%**	**(64.1%)***	62%
Childhood Immunization—4 DTaP	81.8%	**83.5%***	83%
Childhood Immunization—3 IPV	**90.4%**	**92.7%***	89%
Childhood Immunization—1 MMR	**92.6%**	**93.2%**	90%
Childhood Immunization—3 HiB	**85.4%**	**(84.9%)**	76%
Childhood Immunization—3 HBV	**86.1%**	**89.2%***	82%
Childhood Immunization—1 VZV	**83.8%**	**86.0%***	77%
Childhood Immunization—DTP, IPV, & MMR (4:3:1 Series)	78.9%	**81.7%***	80%
Childhood Immunization—DTP, IPV, MMR, HIB, & HBV (4:3:1:3:3 Series)	69.3%	**72.1%***	70%

Notes:

Bolded rates exceed the minimum AHCCCS performance standard.

Nonbolded rates in the current measurement cycle require a CAP.

() Parentheses for current performance indicate a decrease from the previous measurement cycle.

* Statistically significant change from the previous measurement period at $p \leq .05$.

[1] Children's Access to PCPs and Adult's Access to Preventive/Ambulatory Health Services performance measures are measured and reported annually. All other performance measures are measured and reported on a rotating basis to allow health plans an intervention year between reporting periods.

[2] AHCCCS changed the methodology for collecting data and used a data warehouse to gather rate information. In order to have valid comparisons with data collected using the new process, AHCCCS used the data warehouse to recalculate rates for the previous year using the current methodology. Therefore, the rates in this report cannot be directly compared with the rates detailed in the 2006 EQRO report.

[3] The previous remeasurement period for Breast Cancer Screening was Oct. 1, 2002, through Sept. 30, 2004. The current measurement period is Oct. 1, 2003, through Sept. 30, 2005.

[4] The previous remeasurement period for Cervical Cancer Screening and Timeliness of Prenatal Care was Oct. 1, 2003, through Sept. 30, 2004.

Table 3-2 shows the changes from the previous measurement period to the current one. The table shows that 11 of the rates increased, while only 2 rates decreased (i.e., Timeliness of Prenatal Care and Childhood Immunization—3 HiB). Nine of the 11 increasing rate changes were statistically significant ($p \leq .05$). Although the rates for Breast Cancer Screening and Childhood Immunization—1 MMR also increased, they did not increase by a statistically significant amount. Of the two rates that decreased, only the rate for Timeliness of Prenatal Care did so by a statistically significant amount.

The second type of finding compares the current rates with the minimum AHCCCS performance standards. The current rate for 7 of the 11 increasing measures exceeded the minimum AHCCCS performance standard. The four measures that increased but were still not at the minimum AHCCCS performance standard were: Children's Access to PCPs, Adult's Access to Preventive/Ambulatory Health Services, Breast Cancer Screening, and Cervical Cancer Screening, all of which had increased by a statistically significant amount from the previous measurement period, except for Breast Cancer Screening. Notably, both measures with rates that decreased from the previous measurement cycle still exceeded the minimum AHCCCS performance standard. Overall, the number of measures with statewide averages that exceeded the minimum AHCCCS performance standards increased from 6 of the 13 reviewed performance measures (i.e., 46 percent) from the prior year's technical report findings to 9 of the 13 (i.e., 69 percent) for the current year's findings.

Performance Measures—CAPs

Table 3-3 presents the percentage of health plans with a required CAP for each of the 13 performance measures. The table shows that the percentage of plans with a required CAP varied from zero percent of plans for Childhood Immunization—1 VZV to 89 percent of plans for both types of adult cancer screening (i.e., breast and cervical). For adult cancer screening, all of the plans serving adults required a CAP for both measures. The one plan that did not require a CAP for both measures did not serve adult members. Overall, more than half of the performance measures (i.e., 7 of 13) had a CAP required for at least one-third of the plans. Individual plans ranged from two to nine required CAPs for the performance measures, averaging five CAPs per plan.

Table 3-3—Performance Measures – Percent of Plans with a Required CAP *for* All Plans

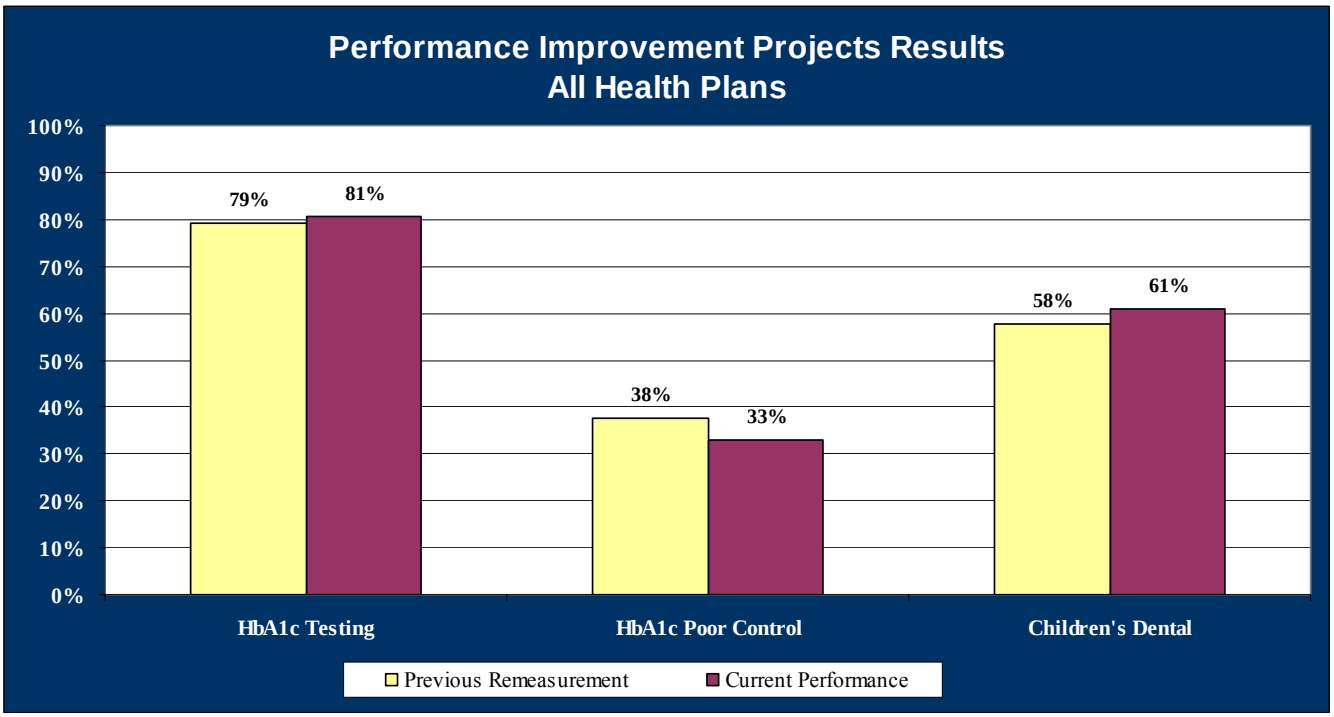
Performance Measure	Percent	Total Number
Children's Access to PCPs	67%	6
Adult's Access to Preventive/Ambulatory Health Services	56%	5
Breast Cancer Screening	89%	8
Cervical Cancer Screening	89%	8
Timeliness of Prenatal Care	44%	4
Childhood Immunization—4 DTP	33%	3
Childhood Immunization—3 IPV	11%	1
Childhood Immunization—1 MMR	11%	1
Childhood Immunization—3 HiB	22%	2
Childhood Immunization—3 HBV	11%	1
Childhood Immunization—1 VZV	0%	0
Childhood Immunization—DTP, IPV, & MMR (4:3:1 Series)	22%	2
Childhood Immunization—DTP, IPV, MMR, HIB, & HBV (4:3:1:3:3 Series)	33%	3
Total Number of CAPs (Average Number of CAPs Per Plan)		**44 (5)**

Review of Performance Improvement Projects (PIPs)

Figure 3-3 presents the statewide rates for the three measures used in the PIPs. All three rates improved between the two measurement cycles. HbA1c Testing improved from 79 percent to 81 percent, exceeding the Medicaid 2005 HEDIS 50th national percentile rate of 78 percent for both measurement periods. HbA1c Control also improved by dropping from 38 percent to 33 percent (lower rates are indicative of better performance). The rates for both years were between the 75th and 90th HEDIS national percentile rates, after adjusting for the measure being reversed. Two caveats should be noted when interpreting these results: (1) DES/CMDP did not participate in the adult diabetes management PIP as it does not provide services to adults, and (2) Care1st was not a participating health plan when the adult diabetes management PIP began.

The statewide rate for Children's Dental increased from 58 percent to 61 percent. Three caveats should be noted, however, when interpreting the results for the Children's Dental PIPs. First, Children's Dental rates are aggregated across Medicaid and KidsCare (Arizona's State Children's Health Insurance Program) rates. Children enrolled in Medicaid account for almost 91 percent of the total PIP population. Second, DES/CMDP does not include the KidsCare population. Third, Care1st was not a participating health plan at the time of initiation of this PIP. These caveats, and those for the adult diabetes management results, do not diminish the finding that performance on all three measures improved between measurement periods.

Figure 3-3—Average PIP Performance Across the Two Most Recent Measurement Periods



Strengths, Opportunities for Improvement, and Recommendations

The next three sections discuss: (1) compliance with standards, (2) performance measures, and (3) PIPs. Each of these three sections presents the strengths found in the documentation provided to HSAG, opportunities for improvement, and recommendations.

Compliance with Standards (Operational and Financial Review)

Strengths

The health plans' compliance with requirements associated with the Delivery System standard was a statewide strength. This strength was evidenced by 95 percent of all Delivery System standards being in Full Compliance and by five of the nine health plans being in Full Compliance with all of the assessed standards in this category. Further, none of the health plans was found to be in Non-Compliance with any of the standards. Lastly, this category had the lowest percentage of required CAPs relative to both the total number of CAPs required and to the number of technical standards within the category.

Opportunities for Improvement and Recommendations

Contractors were required to submit CAPs as a result of areas of non-compliance with technical standards evaluated as part of the AHCCCS OFR. These required CAPs suggested that several opportunities for improvement existed within each health plan's operation. Specific opportunities for improvement that were common to all or most of the health plans included:

- Ensuring that written agreements with delegated entities contain minimum contract provisions.
- Ensuring that written notices of action, extensions of required timelines, and/or decisions related to authorization of services provided to members contain required provisions appropriate to the action, extension, and/or decision.
- Ensuring that reinsurance and claims processing policies and procedures are in compliance with AHCCCS provisions.
- Ensuring that providers comply with Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program requirements and use appropriate EPSDT tools (e.g., ensuring proper use of the EPSDT tracking form and the Parents Evaluation of Developmental Status (PEDS) tool, ensuring oral health screenings are provided during an EPSDT visit, and coordinating care with community agencies to ensure members of EPSDT age are receiving EPSDT services).

Compliance with the technical standards associated with Reinsurance was a clear, statewide opportunity for improvement. Only 26 percent of the assessed standards, statewide, were in Full Compliance with requirements. None of the health plans was in Full Compliance with all of the assessed technical standards in the area of Reinsurance. Four of the nine health plans were not in Full Compliance with any standard within this category. Additionally, the proportion of noncompliant standards in Reinsurance was far larger, at 74 percent, than the next-closest category (i.e., Quality Management, at 42 percent).

Two of the four standards in Reinsurance assessed the health plans' policies and procedures for processing transplant-related costs (i.e., RI1 and RI2). The remaining two standards assessed the health plans' policies and procedures for processing overpayments to the plan (i.e., RI3 and RI4). AHCCCS added the transplant standards to the OFR process to bring attention to the fact that the health plans are required to identify, via the encounter submission process, transplant related services provided. In the future, AHCCCS plans to use this encounter information for reinsurance payment purposes and intended to exemplify, through the OFR process, the lack of submission or identification of those encounters by the health plans. The overpayment standards were added to the OFR process after it was discovered in the previous contract year that health plans were not reporting overpayments to AHCCCS when they occurred. As was expected by AHCCCS, approximately three-quarters of the assessed standards in this category scored less than Full Compliance. The data shows one plan in Full Compliance with three of the four standards and in Substantial Compliance with the fourth standard. In addition, each of the four standards was scored in Full Compliance for at least one plan. Based solely on this data, the weight of the evidence suggests that the standards are sufficiently clear to the plans and that there is either a systemic causal factor common to many of the plans or individual, plan-specific causal factors that are barriers to Full Compliance. Through the OFR and CAP process, AHCCCS is requiring the plans showing the greatest opportunity for improvement to address those areas clearly identified as contributing to the failure to comply with the requirements.

The creation of fully compliant policies and procedures related to processing of encounter information, especially for reinsurance, involves a comparison of current information to the State's requirements. The fact that one health plan was able to do so almost perfectly suggests that the other plans should be able to do so, as well.

Performance Measure Review

Strengths

Two statewide strengths emerged from the performance measure review. First, the State saw a 50 percent relative increase for the number of performance measures with a statewide average rate exceeding the minimum AHCCCS performance standard (i.e., from six measures in the previous measurement cycle to the current nine). Second, rates for 11 of the 13 measures improved, with the 2 measures with declining rates still exceeding the current minimum AHCCCS performance standards.

Opportunities for Improvement and Recommendations

Opportunities for improvement can be prioritized by various methods. One method would suggest that measures with rates that have not yet reached the minimum AHCCCS performance standard should be given higher priority than measures that have reached the minimum standards. This method makes four measures high-priority opportunities for improvement: Children's Access to PCPs, Adult's Access to Preventive/Ambulatory Health Services, Breast Cancer Screening, and Cervical Cancer Screening. Importantly, more than 60 percent of the CAPs from the performance measure review were for these four measures (i.e., 27/44 = 61.4 percent).

An additional method would also suggest that these four measures were high-priority opportunities for improvement. This method compared the average number of CAPs for groups of measures. This method found that four selected measures averaged 6.8 required CAPs per measure, compared with 1.9 CAPs per measure for the other nine measures. The four selected measures, therefore, averaged more than three and a half times as many CAPs per measure compared with the other nine measures.

Both methods for prioritizing opportunities for improvement selected the same four measures, on average, statewide. The measures were both broad (i.e., Children's Access to PCPs and Adult's Access to Preventive/Ambulatory Health Services) and specific (i.e., Breast Cancer Screening and Cervical Cancer Screening). Broadly assessed, the measures were all about timely access to care. Children were not being seen as often as guidelines stated, adults were not receiving preventive and ambulatory care as recommended, and the rates for both measures of women's cancer screening resulted in a required CAP for every health plan with members eligible for the measures.

Improving performance related to timely access to care and services is a challenge statewide. The health plans could, either individually or by participating in work groups, identify commonalities in and/or plan-specific barriers to access in general, analyze the barriers, and identify focused interventions targeting the barriers related to the four specific performance measures. As part of and/or based on the findings from a careful root-cause analysis, the plans with the lowest rates for these measures, shown comparatively in Section 4 and individually in this section, might want to consider one or more of the following activities:

- Conduct surveys of providers and/or members to assist in identifying causal factors contributing to the lack of plan performance at the expected level
- Analyze the performance data for the individual/group providers to identify any patterns that would suggest that the failure to comply is relatively consistent across the providers or that there are clear patterns of poorer performance specific to a select number of participating providers and/or their assigned members
- Institute automated reminder systems both for physicians and members. The physician systems would remind physicians and appropriate office staff of labs, tests, and immunizations that are routinely needed. The member systems would send automated educational mailings (also available in Spanish) to members explaining the value of and need for the labs, tests, and immunizations.
- Institute automated phone calls that remind members to make and/or keep upcoming medical appointments.
- Research and institute incentives for both members and providers to improve preventive health visit rates.
- Enhance educational materials (also available in Spanish) to include maps showing members the closest labs/testing facilities and the transportation available to get there, such as bus routes and schedules.
- Enhance focused and targeted outreach and/or case management follow-up activities for members falling behind by more than a specified period of time (e.g., three months) in obtaining routine labs, tests, and immunizations.

AHCCCS has similarly recommended a number of these strategies to the health plans and is working with the plans on several others. The required CAPs submitted by the health plans also included a number of the recommended approaches as part of the health plans' proposed improvement strategies.

Review of PIPs

Strengths

Conducting PIPs appeared to be an overall strength for the State's health plans. The rates improved for all three assessed measures. Further, the statewide rates for both measures of adult diabetes management were above average from a national perspective.

Opportunities for Improvement and Recommendations

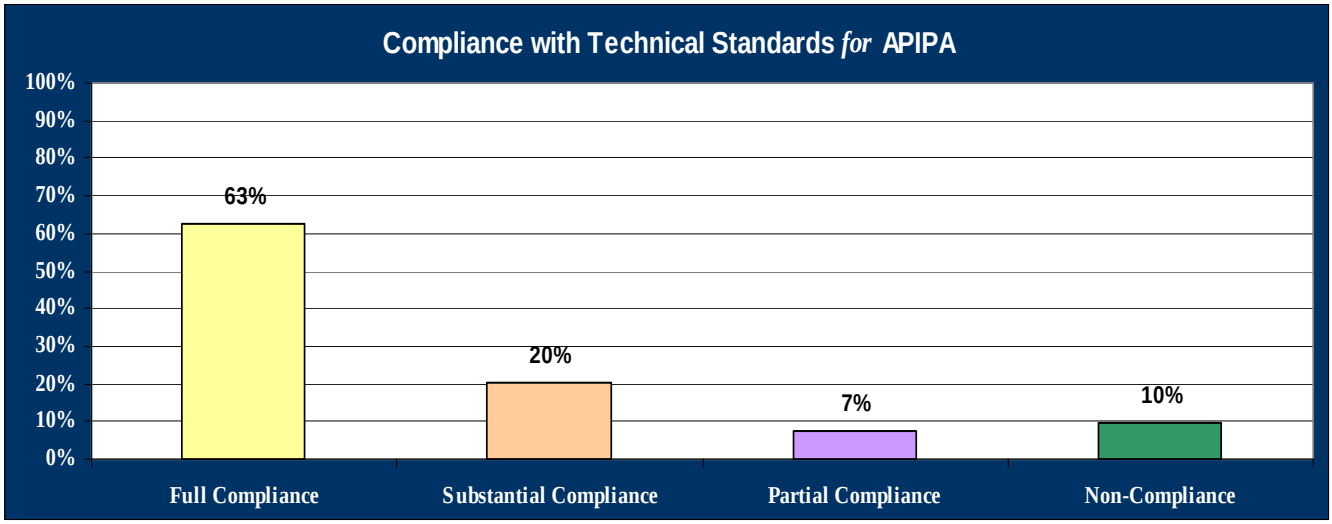
While there are always opportunities for improvement wherever performance is not perfect, investing time and resources in performance improvement activities must be prioritized to make the best use of limited resources and where the failure to improve performance poses the greatest risk or potential for adverse outcomes. For this reason, and given the strong performance on the part of the health plans related to their PIPs, no specific statewide opportunities for improvement or recommendations are offered. Instead, opportunities for improvement and recommendations related to PIPs are listed in the following plan-specific findings where they are appropriate to the plan-specific results.

Arizona Physicians IPA (APIPA)

Compliance with Standards (Operational and Financial Review)

Figure 3-4 presents the APIPA percentage of compliance with the technical standards selected for review in CY 2005–2006. The percentages of the standards in Full Compliance, Substantial Compliance, Partial Compliance, and Non-Compliance are shown separately. The figure shows that only 63 percent of APIPA's technical standards were assessed as being in Full Compliance with the requirements. The technical standards that were not in Full Compliance were evaluated as being in Substantial Compliance, Partial Compliance, or Non-Compliance for 20 percent, 7 percent, and 10 percent of the standards, respectively.

Figure 3-4—Compliance with Technical Standards *for* APIPA



When interpreting the information in Figure 3-4, the difference between at least Partial Compliance and Full Compliance reflects a scenario in which the health plan seems to know the intent of the technical standards but is not fully achieving compliance with the requirements. This scenario contrasts with Non-Compliance, which indicates that the health plan might not understand the intent of the technical standards. In the first case (i.e., understanding but not fully achieving compliance with the technical standards), the health plan might make large strides in attaining Full Compliance with relatively little effort. Moving a technical standard from Non-Compliance to Full Compliance, however, might require technical assistance/training and other activities, such as those delineated in the section on opportunities for improvement and recommendations.

Figure 3-5 shows the extent of compliance for each of the major areas within the technical standards. The figure portrays both areas of strength and opportunities for improvement. In each category, the figure shows the level of compliance with the technical standards based on Full Compliance, Substantial Compliance, Partial Compliance, and Non-Compliance in a stacked-bar format.

Figure 3-5—Categorized Levels of Compliance with Technical Standards *for* APIPA

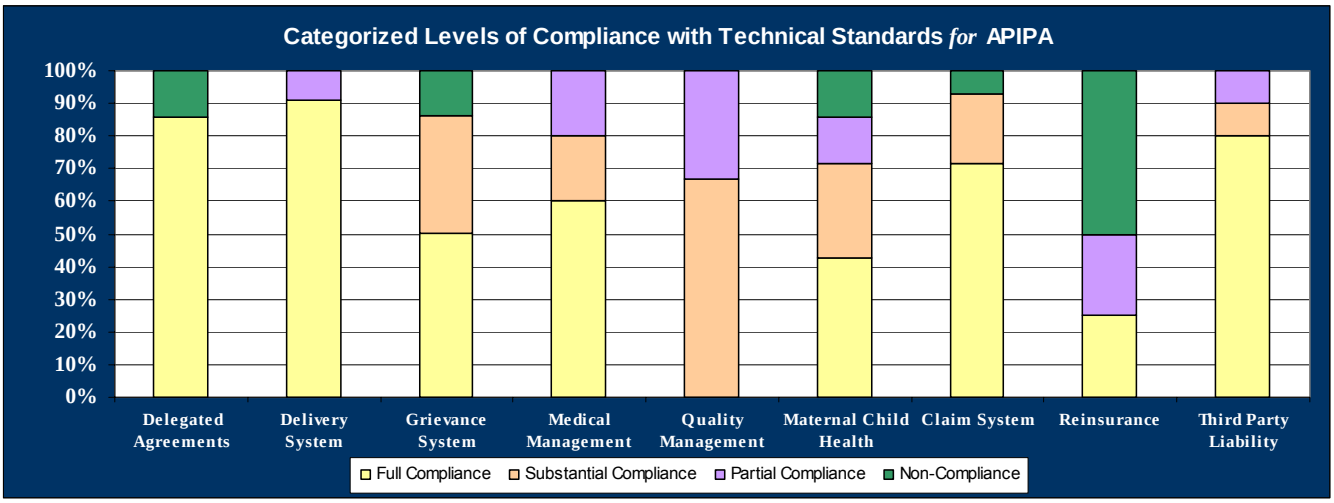


Figure 3-5 shows Delivery System to be an area of performance strength, followed by Delegated Agreements and Third Party Liability, with 91 percent, 86 percent, and 80 percent, respectively, of the standards in Full Compliance. Conversely, Figure 3-5 also shows opportunities for APIPA's performance to improve on the technical standards. For example, half of the Reinsurance standards were in Non-Compliance. Further, none of the three technical standards were in Full Compliance for Quality Management and only 43 percent and 50 percent were in Full Compliance for Maternal and Child Health and for Grievance System, respectively.

CAPs for Compliance with Standards

Table 3-4 presents each of the categories of technical standards reviewed, the number of CAPs required, each category's percentage of all CAPs, the number of technical standards in each category, and the percentage of the technical standards with a required CAP for each category.

Table 3-4—CAP Overview *for* APIPA

Categories of Technical Standards	Number of CAPs	Percent of Total CAPs	Total Number of Standards	CAPs as a Percent of Standards
Delegated Agreements	1	3%	7	14%
Delivery System	1	3%	11	9%
Grievance System	12	38%	22	55%
Medical Management	2	6%	5	40%
Quality Management	3	9%	3	100%
Maternal and Child Health	4	13%	7	57%
Claims System	4	13%	14	29%
Reinsurance	3	9%	4	75%
Third Party Liability	2	6%	10	20%
Total	**32**	**100%**	**83**	**39%**

APIPA required only one CAP each for Delegated Agreements and Delivery System, suggesting that those categories are areas of strength. The table also shows that, based on the number of CAPs required, Grievance System had the greatest opportunities for improvement. There were also opportunities for improvement in Medical Management, Quality Management, Maternal and Child Health, and Reinsurance. These opportunities for improvement were based on categories that had 40 percent or more of standards requiring a CAP. Overall for APIPA, 39 percent of the technical standards required a CAP.

Performance Measure Review

Table 3-5 shows the separate performance measures for the two most recent time periods, along with the statistical significance for each of the changes in rates over time. The table also presents the minimum AHCCCS performance standards and whether a CAP was required.

Table 3-5—Performance Measurement Program *for* APIPA			
Performance Measure	Previous Measurement Period[1]	Actual Performance for Oct. 1, 2004, to Sept. 30, 2005	Minimum AHCCCS Performance Standard
Children's Access to PCPs[2]	77.4%	78.0%*	79%
Adult's Access to Preventive/Ambulatory Health Services[2]	79.7%	**80.4%***	80%
Breast Cancer Screening[2,3]	47.7%	51.4%*	57%
Cervical Cancer Screening[2,4]	55.7%	58.6%*	61%
Timeliness of Prenatal Care[4]	**66.4%**	**(63.3%)***	62%
Childhood Immunization—4 DTaP	80.7%	**84.5%***	83%
Childhood Immunization—3 IPV	**89.9%**	**93.6%***	89%
Childhood Immunization—1 MMR	**90.7%**	**93.8%***	90%
Childhood Immunization—3 HiB	**82.8%**	**87.6%***	76%
Childhood Immunization—3 HBV	**87.8%**	**92.3%***	82%
Childhood Immunization—1 VZV	**80.7%**	**86.0%***	77%
Childhood Immunization—DTP, IPV, & MMR (4:3:1 Series)	77.5%	**83.0%***	80%
Childhood Immunization—DTP, IPV, MMR, HIB, & HBV (4:3:1:3:3 Series)	69.3%	**76.4%***	70%

Notes:

Bolded rates exceed the minimum AHCCCS performance standard.

Nonbolded rates in the current measurement cycle require a CAP.

() Parentheses for current performance indicate a decrease from the previous measurement cycle.

* Statistically significant change from the previous measurement period at $p \leq .05$.

[1] Children's Access to PCPs and Adult's Access to Preventive/Ambulatory Health Services performance measures are measured and reported annually. All other performance measures are measured and reported on a rotating basis to allow health plans an intervention year between reporting periods.

[2] AHCCCS changed the methodology for collecting data and used a data warehouse to gather rate information. In order to have valid comparisons with data collected utilizing the new process, AHCCCS used the data warehouse to recalculate rates for the previous year using the current methodology. Therefore, the rates in this report cannot be directly compared with the rates detailed in the 2006 EQRO report.

[3] The previous remeasurement period for Breast Cancer Screening was Oct. 1, 2002, through Sept. 30, 2004. The current measurement period is Oct. 1, 2003, through Sept. 30, 2005.

[4] The previous remeasurement period for Cervical Cancer Screening and Timeliness of Prenatal Care was Oct. 1, 2003, through Sept. 30, 2004.

The bolded rates show that the plan increased the number of measures exceeding the minimum AHCCCS performance standards from 6 to 10, leaving three nonbolded rates that require CAPs. Only one of the 13 rates (i.e., Timeliness of Prenatal Care) declined between measurement periods. The rate for every performance measure changed by a statistically significant amount (i.e., $p \leq .05$) between the two measurement cycles. Although Timeliness of Prenatal Care decreased, the current

rate still exceeded the minimum AHCCCS performance standard. Overall, the plan is to be commended on its improvements to the performance measure rates between the two most recent measurement periods.

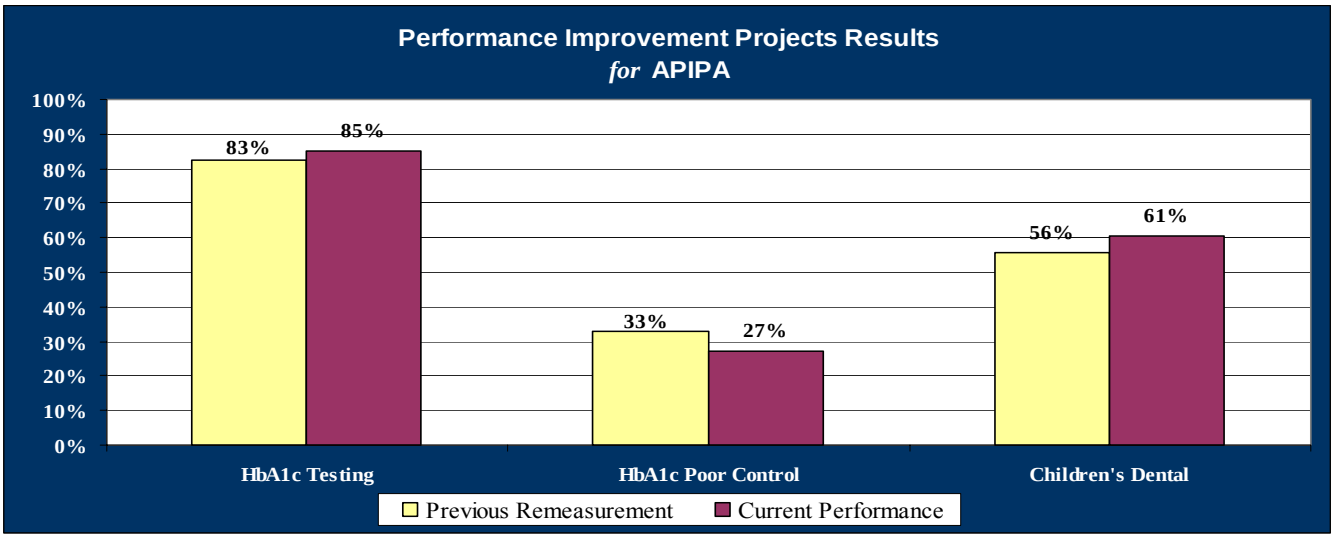
Performance Measures—CAPs

Table 3-5 shows that the three performance measures requiring a CAP were Children's Access to PCPs, Breast Cancer Screening, and Cervical Cancer Screening because performance on those measures did not reach the minimum AHCCCS performance standards. Importantly, performance for Breast Cancer Screening was almost six percentage points below the minimum AHCCCS performance standard rate and is an area that should be a high priority for improvement by the health plan.

Review of PIPs

Figure 3-6 presents the results of APIPA's two PIPs, adult diabetes management and children's oral health. The figure shows improvement in each of the measures used to assess these PIPs. In addition, the rates for the diabetes indicators were strong from a national perspective. HbA1c testing was above the national 75th percentile HEDIS Medicaid rate of 84.1 percent. The HbA1c control measure, for which a decrease (as shown in the figure) indicates improvement, almost reached the HEDIS 90th percentile rate, after adjusting for the reversed structure of the measure in which lower rates indicate better care. The children's oral health measure improved from 56 percent to 61 percent.

Figure 3-6—PIP Results *for* APIPA



While implementing a number of different interventions, APIPA reported that a combination of phone and mail strategies was the most effective in improving compliance. APIPA mailed more than 215,000 notifications and reminders, made more than 40,000 phone calls, and using its automated telephone outreach program, placed calls to more than 230,000 members. The plan attributed its strong performance on the diabetes PIP, in part, to interventions that included improving systems for the early identification of diabetic members; engaging the case manager, physician, and member in treatment planning; having case managers contact the physician for the results of the HbA1c tests; and reviewing compliance through the plan's pharmacy benefit manager.

Strengths, Opportunities for Improvement, and Recommendations for APIPA

The next three sections discuss: (1) compliance with standards, (2) performance measures, and (3) PIPs. Each of these three sections presents the strengths found in the documentation provided to HSAG, opportunities for improvement, and recommendations.

Compliance with Standards (Operational and Financial Review)

Strengths

Compliance with the technical standards associated with Delivery System was a recognized strength for the plan. This strength was evidenced by 91 percent of all Delivery System standards being in Full Compliance, followed by Delegated Agreements at 86 percent. The small numbers and percentages of CAPs for these two categories also showed that Delivery System and Delegated Agreements were strengths for APIPA.

Opportunities for Improvement and Recommendations

The data presented also provided evidence of significant opportunities for improvement in APIPA's performance related to the technical standards. Reinsurance, Quality Management, Maternal and Child Health, and Grievance System are areas with opportunities for improvement, with relatively high proportions of standards not meeting the requirements. Quality improvement bodies/committees would typically prioritize fewer than four of nine identified areas for improvement activities to be accomplished simultaneously within a specified time period (e.g., quarterly, annually, etc.). Nonetheless, all four of these categories of standards were scored substantially lower than would be considered acceptable and should be addressed by the plan.

Reinsurance has been shown to be a statewide opportunity for improvement, and APIPA is not excluded from that finding, with half of the standards given a Non-Compliance score. As previously shown, the State regulations appear to be sufficiently clear for the plan to align its policies and procedures to ensure that processes are in place for properly handling reinsurance issues. The creation of fully compliant policies and procedures related to processing of encounter information, especially for reinsurance, involves a comparison of current information to the State's requirements.

Recommendation: The health plan should consider appointing a time-limited project work group of key plan personnel with expertise in AHCCCS' requirements, the plan's current policy, and technical requirements/systems. Members of the work group should be charged with conducting a root-cause analysis of the failure to fully comply with the requirements and develop and implement strategic, focused interventions to bring the plan's reinsurance policies and procedures into Full Compliance with the State's requirements before the next review cycle.

For Maternal and Child Health, five of the seven standards within the category involved compliance with EPSDT requirements. A sixth standard reviews the training and use of the Parents Evaluation of Developmental Status (PEDS) tools, which has ramifications for physician practice, member health, and State monitoring of children's services. The only standard that was not directly related solely to children's health assessed the extent to which services were coordinated with other agencies according to State and federal requirements. This category of standards set minimum

levels of care to ensure that some of the most potentially vulnerable plan members (i.e., children) have timely access to quality care and services. Further, children are less likely to complain about care than are adults, and adults are often not sufficiently versed in children's health care needs and guidelines to be the most appropriate advocates for their children.

Recommendation: The plan should consider conducting a crosswalk comparison of the EPSDT guidelines and associated State and federal requirements to its policies and procedures to ensure that the plan policies fully address all guidelines/requirements and are clear and explicit in defining procedures to be followed and processes for monitoring compliance with the requirements. The plan should also consider strengthening its current monitoring processes related to the frequency of monitoring and the completeness of the review tools, including the EPSDT Tracking Form, used to determine if and to what degree performance is in compliance with the requirements and needed gains are being achieved. Corrective actions are currently underway to address the deficiency related to the tracking form.

For Grievance System, the current review included 22 standards that covered several aspects of grievance processing and reporting. Appropriate grievance systems can be an important source of information about areas of need for quality improvement activities, and appropriately structured and responsive grievance systems can markedly improve member satisfaction. Grievance systems are also important for transparency, which is fundamental to timely access to quality care as well as to quality improvement.

Recommendation: The plan should consider initiating a comprehensive evaluation of its grievance system structure and processes that could include flow-charting both current and ideal processes to identify areas of performance vulnerability and opportunities to strengthen both performance and checks-and-balances systems of monitoring. Ideally, the evaluation would identify the factors that are contributing to the failure to fully comply with requirements (e.g., incomplete or unclear policies and procedures, staff performance such as failure to perform required actions within required time frames or to document the actions, failure of the plan to conduct sufficiently detailed and frequent monitoring, etc.). The plan should also consider identifying opportunities to increasingly automate systems for logging and tracking information and actions related to the processing of grievances. For example, Technical Standard GS5 states: "The Health Plan provides the member written notice of the reason for the decision to extend the timeframe." This standard examines standing policy and the methods implemented for complying with the requirement. The standard received a Non-Compliance score. This would be an excellent opportunity for the plan to automate logging and tracking of the timelines and required actions (i.e., sending a notice requesting an extension that includes the reason) and for auto-generating the notices with the reason for the extension built in as a required field, if these methods are not already in place.

The scores for Quality Management are of some concern because they relate to the Grievance System results. There are only three standards in the Quality Management category. Although two standards were in Substantial Compliance (i.e., timely provisional credentialing and resolution of quality-of-care/service issues raised by enrolled members and contracted providers) and one standard was in Partial Compliance (i.e., a process for reviewing and evaluating quality-of-care complaints and allegations), these issues are fundamental to quality health care and member satisfaction.

Recommendation: The plan should consider coordinating its performance improvement activities related to the Grievance System with those related to the timely resolution of quality-of-care/service issues raised by enrolled members, as well as reviewing and evaluating quality-of-care complaints and allegations, to address the related issues in a manner that capitalizes on the interdepartmental nature of the two categories of standards (i.e., Grievance System and Quality Management).

Performance Measure Review

Strengths

Three strengths emerged from the performance measure review. First, the plan saw a 67 percent relative increase for the number of performance measures exceeding the minimum AHCCCS performance standard (i.e., from 6 measures in the previous measurement cycle to 10). Second, rates for 12 of the 13 measures improved, with the single measure showing a declining rate still exceeding the current minimum AHCCCS performance standard. Third, childhood immunization stands as an area of strength for the plan. In particular, the rates for the childhood immunizations consisting of three Haemophilus influenzae type b (HiB), three hepatitis 3 virus (HBV), and one varicella zoster virus (VZV) exceeded the minimum AHCCCS performance standards by approximately 12, 10, and 9 percentage points, respectively.

Opportunities for Improvement and Recommendations

Three opportunities for improvement were presented for the performance measures: Children's Access to PCPs, Breast Cancer Screening, and Cervical Cancer Screening. The rates for these measures were below the minimum AHCCCS performance standards, but not uniformly below the minimum standards. For example, the rate for Children's Access to PCPs was only one percentage point below the minimum AHCCCS performance standard, whereas the rate for Breast Cancer Screening was approximately 6 percentage points below the minimum standard. Cervical Cancer Screening was almost 3 percentage points lower than the minimum standard. For this reason, the plan should consider prioritizing measures that need the most immediate attention to ensure that there is sufficient time to implement improvement activities and to demonstrate improvement in performance to a level that meets or exceeds the AHCCCS minimum-required level on all three measures before the next measurement cycle.

Children’s Access to PCPs can be more difficult to improve than many other measures. One contributing factor may be that for appointments for children, the schedules of both the child and the person bringing the child to the PCP are involved, whereas appointments for adults typically involve just the schedule of the adult visiting the PCP on his or her own.

Recommendation: In addition to identifying other probable causes for failing to meet the AHCCCS minimum performance standard and implementing targeted interventions to improve performance, the plan should consider comparing the hours of provider availability and the hours of available public transportation with the times of the day and days of the week that working parents whose children are eligible for Medicaid services can typically bring their children to see a PCP. If indicated by the analysis, the plan should require increased provider availability in the evenings and on weekends.

Breast and Cervical Cancer Screening might require very different interventions (i.e., changes) to improve the rates because both of these services are frequently not performed during a routine office visit. Quite often, women must make additional appointments for these screenings, and typically with a provider other than their PCP and in a different location.

Recommendation: In addition to identifying other probable causes for not meeting the minimum required rates and implementing targeted interventions, the plan should consider exploring opportunities and strategies to provide one or more of the required services during any type of office visit, and consolidating radiology and the office visit as though they were a single appointment. In addition, if not currently in place, automated notices to physicians identifying members due for the required screenings and automated reminders and educational information sent to members may positively impact the performance rates.

Review of PIPs

Strengths

Conducting mandated PIPs was an overall strength for the health plan. The rates improved for all three assessed measures. The rates for both measures of adult diabetes management were considerably above average from a national perspective.

Opportunities for Improvement and Recommendations

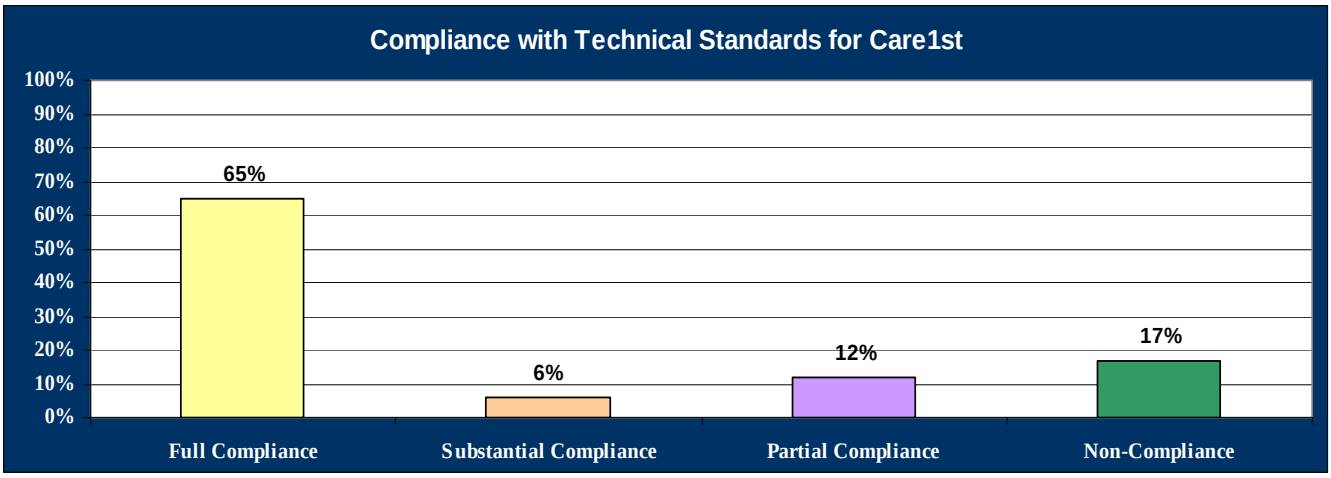
While opportunities for improvement exist wherever performance is not perfect, improvement activities must be prioritized to make the best use of limited resources. Given the strong performance of the plan, there are no specific recommendations for APIPA for improving performance for the PIPs.

Care1st Healthplan of Arizona (Care1st)

Compliance with Standards (Operational and Financial Review)

Figure 3-7 shows the Care1st percentage of compliance with the technical standards selected for review in CY 2005–2006. The percentages of standards in Full Compliance, Substantial Compliance, Partial Compliance, and Non-Compliance are shown separately. The figure shows that only 65 percent of Care1st's technical standards were in Full Compliance with the requirements. The technical standards that were not in Full Compliance were in Substantial, Partial, or Non-Compliance for 6 percent, 12 percent, and 17 percent of the standards, respectively.

Figure 3-7—Compliance with Technical Standards *for* Care1st



When interpreting the information in Figure 3-7, the difference between at least Partial Compliance and Full Compliance reflects a scenario in which the health plan seems to know the intent of the technical standards but is not fully achieving compliance with the requirements. This scenario contrasts with Non-Compliance, which indicates that the health plan might not understand the intent of the technical standards. In the first case (i.e., understanding but not fully achieving full compliance), the health plan might make large strides in attaining Full Compliance with relatively little effort. Moving a technical standard from Non-Compliance to Full Compliance, however, might require technical assistance and other activities, such as those delineated in the section on opportunities for improvement and recommendations. Importantly, however, the percentage of standards in Non-Compliance, at 17 percent, was almost twice the statewide average of 9 percent.

Figure 3-8 shows the extent of compliance for each of the major areas within the technical standards. The figure shows both areas of strength and opportunities for improvement. In each category, the figure shows the level of compliance with the technical standards based on Full Compliance, Substantial Compliance, Partial Compliance, and Non-Compliance in a stacked-bar format.

Figure 3-8—Categorized Levels of Compliance with Technical Standards *for* Care1st

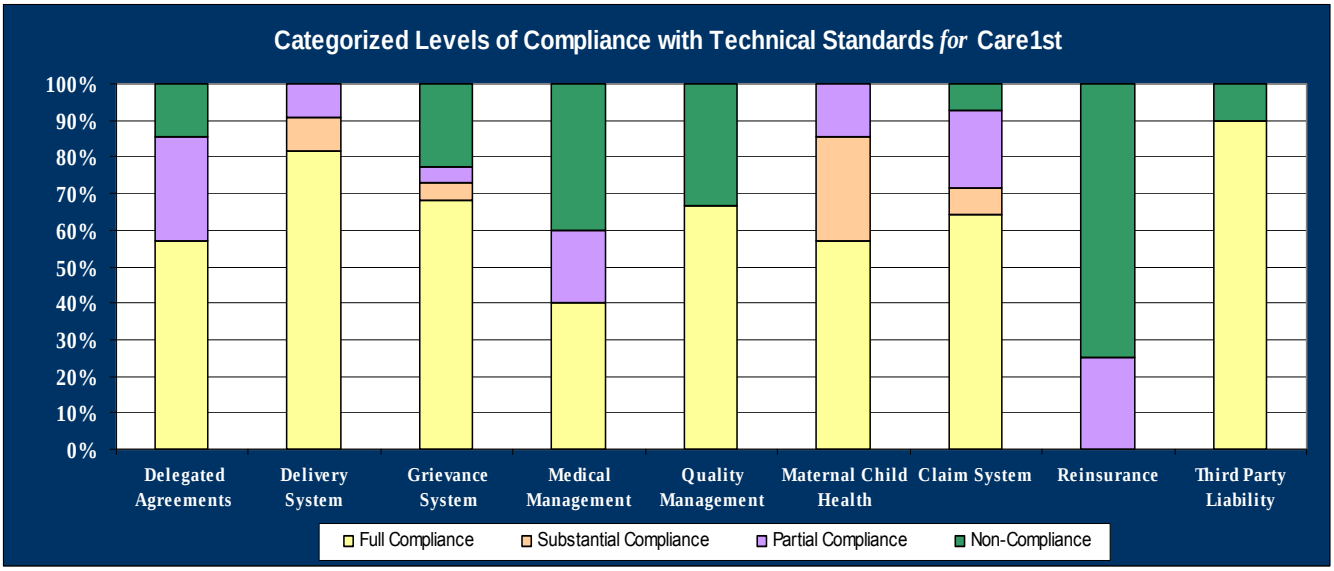


Figure 3-8 shows the difficulty in prioritizing areas of strength or opportunities for improvement from the type of data displayed. For example, Delivery System technical standards were 82 percent in Full Compliance, but 91 percent were in at least substantial compliance (i.e., the sum of Full and Substantial Compliance). The remaining 9 percent were in Partial Compliance. For Third Party Liability, 90 percent were in Full Compliance but 10 percent were in Non-Compliance. Given the scoring system and the differing priorities that individuals would place on the various standards, there is no objective way to assert which standard out-performed the other. Both categories of standards are, therefore, acknowledged as high performers.

The figure also shows significant opportunities for improvement for Care1st's performance related to the technical standards, particularly for Reinsurance. Of the four standards within Reinsurance, one was in Partial Compliance and three were in Non-Compliance.

Medical Management had only two of five standards (i.e., 40 percent) in Full Compliance, no standard in Substantial Compliance (i.e., 0 percent and, therefore, not depicted on the stacked-bar graph), one standard in Partial Compliance (i.e., 20 percent), and two standards in Non-Compliance (i.e., 40 percent). Overall, there were as many standards in Non-Compliance as there were in Full Compliance for this category.

For the remaining categories of standards, none of them was significantly more compliant. On balance, at least seven of the nine categories showed substantively important opportunities for improvement.

CAPs for Compliance with Standards

Table 3-6 presents each of the categories of technical standards reviewed, the number of CAPs required, each category's percentage of all CAPs, the number of technical standards in each category, and the percentage of technical standards with a required CAP for each category.

Table 3-6—CAP Overview *for* Care1st				
Categories of Technical Standards	**Number of CAPs**	**Percent of Total CAPs**	**Total Number of Standards**	**CAPs as a Percent of Standards**
Delegated Agreements	2	7%	7	29%
Delivery System	3	10%	11	27%
Grievance System	7	24%	22	32%
Medical Management	3	10%	5	60%
Quality Management	1	3%	3	33%
Maternal and Child Health	3	10%	7	43%
Claims System	5	17%	14	36%
Reinsurance	4	14%	4	100%
Third Party Liability	1	3%	10	10%
Total	**29**	**100%**	**83**	**35%**

Care1st was required to submit only one CAP each for Quality Management, which had three standards, and for Third Party Liability. Performance for Third Party Liability could be considered a strength based on the relatively low percent (i.e., 10 percent) of required CAPs proportionate to the number of standards reviewed. The table also shows that, based on the number of CAPs required, Grievance System, Claims System, and Reinsurance constituted 55 percent of the CAPs in the current review period. When CAPs were assessed as a percentage of the number of standards within each category, the Reinsurance, Medical Management, and Maternal and Child Health rates of required CAPs were 100 percent, 60 percent, and 43 percent, respectively. Overall, 35 percent of Care1st's technical standards required a CAP.

Performance Measure Review

Table 3-7 shows the separate performance measures for the two most recent time periods, along with the statistical significance for each of the changes in rates over time. Additionally, the table presents the minimum AHCCCS performance standards and whether a CAP was required.

Table 3-7—Performance Measurement Program *for* Care1st			
Performance Measure	Previous Measurement Period[1]	Actual Performance for Oct. 1, 2004, to Sept. 30, 2005	Minimum AHCCCS Performance Standard
Children's Access to PCPs[2]	69.1%	77.7%*	79%
Adult's Access to Preventive/Ambulatory Health Services[2]	66.2%	73.5%*	80%
Breast Cancer Screening[2,3]	N/A	36.1%	57%
Cervical Cancer Screening[2,4]	30.3%	48.8%*	61%
Timeliness of Prenatal Care[4]	44.1%	59.3%*	62%
Childhood Immunization—4 DTaP	N/A	74.1%	83%
Childhood Immunization—3 IPV	N/A	**89.8%**	89%
Childhood Immunization—1 MMR	N/A	89.8%	90%
Childhood Immunization—3 HiB	N/A	**84.3%**	76%
Childhood Immunization—3 HBV	N/A	**86.1%**	82%
Childhood Immunization—1 VZV	N/A	**80.7%**	77%
Childhood Immunization—DTP, IPV, & MMR (4:3:1 Series)	N/A	72.3%	80%
Childhood Immunization—DTP, IPV, MMR, HIB, & HBV (4:3:1:3:3 Series)	N/A	66.3%	70%

Notes:

Bolded rates exceed the minimum AHCCCS performance standard.

Nonbolded rates in the current measurement cycle require a CAP.

N/A is Not Applicable

() Parentheses for current performance indicate a decrease from the previous measurement cycle.

* Statistically significant change from the previous measurement period at $p \leq .05$.

[1] Children's Access to PCPs and Adult's Access to Preventive/Ambulatory Health Services performance measures are measured and reported annually. All other performance measures are measured and reported on a rotating basis to allow health plans an intervention year between reporting periods.

[2] AHCCCS changed the methodology for collecting data and used a data warehouse to gather rate information. In order to have valid comparisons with data collected using the new process, AHCCCS used the data warehouse to recalculate rates for the previous year using the current methodology. Therefore, the rates in this report cannot be directly compared with the rates detailed in the 2006 EQRO report.

[3] The previous remeasurement period for Breast Cancer Screening was Oct. 1, 2002, through Sept. 30, 2004. The current measurement period is Oct. 1, 2003, through Sept. 30, 2005.

[4] The previous remeasurement period for Cervical Cancer Screening and Timeliness of Prenatal Care was Oct. 1, 2003, through Sept. 30, 2004.

The bolded rates show that the plan is currently exceeding the minimum AHCCCS performance standards for four measures, leaving the nine nonbolded rates that require CAPs. All four comparable rates improved by a statistically significant amount ($p \leq .05$) between measurement cycles.

Performance Measures—CAPs

Table 3-7 shows that 9 of the 13 performance measures required a CAP by not reaching the minimum AHCCCS performance standards, including all four measures with previous comparative data. The four measures that did not require a CAP were: Childhood Immunization—3 IPV, 3 HiB, 3 HBV, and 1 VZV. Nonetheless, both the number and the percentage of performance measures that required a CAP suggest that Care1st should strongly consider empowering an oversight committee that is solely tasked with improving the performance measure rates. Although the lack of previous, comparable data might suggest that the plan has not had a sufficient opportunity to achieve appropriate rates, the plan was required by contract to be appropriately staffed and equipped to provide timely access to quality care upon accepting Medicaid members.

Review of PIPs

Care1st had not been a contractor long enough to include information for the AHCCCS mandated Diabetes Management or Children's Dental PIPs. Care1st does, however, have two self-selected PIPs under way for Diabetes Management and Asthma Management. The methodologies had been designed and baseline data collected for both of these PIPs as documented and included in the Care1st data/information that AHCCCS provided to HSAG.

Strengths, Opportunities for Improvement, and Recommendations for Care1st

The next three sections discuss: (1) compliance with standards, (2) performance measures, and (3) PIPs. Each of these three sections presents the strengths found in the documentation, opportunities for improvement, and recommendations.

Compliance with Standards (Operational and Financial Review)

Strengths

Compliance with the standards for Delivery System and for Third Party Liability was a relative strength for the plan. Both categories of standards were at least 90 percent in Full or Substantial Compliance. From the perspective of required CAPs as a percentage of the standards reviewed, Delegated Agreements was also a relative strength.

Opportunities for Improvement and Recommendations

Grievance System, Medical Management, and Reinsurance showed the greatest opportunities for improvement for compliance with technical standards. This finding was based on a combination of the results shown in Figure 3-8 and in Table 3-6.

The current review included 22 standards associated with the plan's Grievance System, covering several aspects of grievance processing and reporting. Appropriate grievance systems can be an important source of information about areas of need for quality improvement activities, and appropriately structured and responsive grievance systems can markedly improve member satisfaction. Grievance systems are also important for transparency, which is fundamental to timely access to quality care and to quality improvement.

Recommendation: The plan should consider initiating a comprehensive evaluation of its grievance system structure and processes, which could include flow-charting both current and ideal processes to identify areas of performance vulnerability and opportunities to strengthen both performance and checks-and-balances systems of monitoring. Ideally, the evaluation would identify the factors that are contributing to the failure to fully comply with requirements (i.e., incomplete or unclear policies and procedures, staff performance such as failure to perform required actions within required time frames or failure to document the actions, and failure of the plan to conduct sufficiently detailed and frequent monitoring, etc.). The plan should also consider identifying opportunities to increasingly automate systems for logging and tracking information and actions related to the processing of grievances. For example, Technical Standard GS5 states: "The Health Plan provides the member written notice of the reason for the decision to extend the timeframe." This standard examined standing policy and the methods implemented for complying with the requirement. The standard was scored as Non-Compliant. This would be an excellent opportunity for the plan to automate logging and tracking of the timelines and required actions (i.e., sending a notice requesting an extension that includes the reason) and for auto-generating the notices with the reason for the extension built in as a required field, if these methods are not already in place.

The review of Medical Management covered five standards, two of which were related to catastrophic and transplant management. Both of those standards were in Full Compliance. This finding contrasted with the scores for the transplantation standards in the Reinsurance category, which were in Non-Compliance and Partial Compliance for RI1 and RI2, respectively. The policies and procedures in place for handling the medical aspects of transplantation seem, therefore, more in accord with State regulations than the related aspects of billing.

The scores for the remaining three standards in Medical Management showed opportunities for improvement. These standards were associated with utilization management through the use of the plan's encounter data for member and physician profiling, in addition to the other ways in which the data is used. The use of data for improving quality is a hallmark of health care management for providers. The benefits of a well-functioning and informative data system extend considerably beyond being in full compliance with the associated technical standards; they can be seen in almost every aspect of the operation of the organization. Given that the purpose of the plan is to provide for the health care needs of its members, Care1st will be limited in its ability to assess whether it is accomplishing this goal until policies and procedures are in place that are fully compliant with the Medical Management technical standards.

Recommendations: To improve compliance with the Medical Management technical standards, the plan should consider assigning the highest priority for improvement actions to standard MM1 (i.e., "The Health Plan has implemented procedures for utilization management program requirements, which are consistent with AHCCCS standards"). The AHCCCS standards are provided to the plans and require no assumptions in order for the plans to be fully compliant with them. The plan should consider implementing strategies to develop the cultural characteristic of fully using its contractual requirements (i.e., State and federal) in the development of written policies and procedures that accurately reflect actual and best practices. Additionally, the plan should consider ensuring that its written agreements with delegated entities, who serve as an extension to the plan, contain AHCCCS-mandated subcontract provisions. The plan should also consider appointing and empowering a time-limited work group to review and ensure that its procedures for the utilization management program requirements are appropriately in place and fully consistent with AHCCCS

standards. Care1st should also consider conducting a regular schedule of reviews by an interdepartmental review team to monitor the extent to which Care1st is using and reflecting the most current State and federal guidelines in its written policies, procedures, and delegation agreements.

Reinsurance standards, a statewide opportunity for improvement, were particularly troublesome for Care1st. Of the four technical standards within the category, Care1st received a Non-Compliance score for three of the standards and a Partial Compliance score for the fourth. These scores, overall, were the lowest in the State for this category in the compliance review. As previously shown, the AHCCCS regulations appear to be sufficiently clear for the plan to align its policies and procedures with the AHCCCS requirements to ensure that processes are in place for properly handling reinsurance issues. The creation of fully compliant policies and procedures related to processing of encounter information, especially for reinsurance, involves a comparison of current information to AHCCCS requirements.

Recommendation: Care1st should consider appointing a time-limited work group to comprehensively review the plan's reinsurance policies and procedures compared with AHCCCS requirements and to implement revisions that will bring the plan into full compliance with the State's requirements before the next review cycle.

Performance Measure Review

Strengths

Two types of strengths were seen in the performance measure review. First, the four measures with comparable data all increased by a statistically significant amount. Second, four immunization measures exceeded the minimum AHCCCS performance standards. Nonetheless, both of these types of strengths were somewhat mitigated by overarching opportunities for improvement, as described in the following section.

Opportunities for Improvement and Recommendations

The first type of strength (i.e., statistical improvement in the four comparable measures) was mitigated by the fact that none of the four rates reached the minimum AHCCCS performance standard. Although the rates increased, they still represented opportunities for improvement. The second type of strength (i.e., four immunization rates exceeded the minimum AHCCCS performance standards) was mitigated by the four immunization standards that did not reach the minimum AHCCCS performance standards. In fact, the four immunization measures that did exceed the minimum AHCCCS performance standards were the only measures that did so. Overall, nine measures showed opportunities for improvement in the plan's performance measures.

With 9 of 13 measures still needing improvement, the quality improvement issue becomes one of finding the root causes of the failure to achieve sufficiently high rates across almost all of the performance measures reviewed.

Recommendation: To improve performance on the required measures, the plan should consider drawing on the opportunities for improvement related to using data for medical management from

the compliance with standards review. It may be difficult for the plan to make substantively large improvements in its performance measures until it formally and regularly uses data to assess, intervene in, and monitor the delivery of care through member and physician profiling and associated activities. Once these activities are institutionalized, the plan would then be able to focus the activities and related interventions on the nine performance measures that are still below the minimum AHCCCS performance standards. These interventions could take the form of automated reminders to physicians (i.e., for labs, tests, and vaccinations) and automated contacts for members (e.g., to schedule appointments and as reminders for appointments).

Review of PIPs

Strengths

This section is not applicable because Care1st, while having initiated and collected baseline data for two self-selected PIPS—Diabetes Management and Asthma Management, had not been a contractor long enough to include information for the AHCCCS-mandated Diabetes Management and Children's Dental PIPs.

Opportunities for Improvement and Recommendations

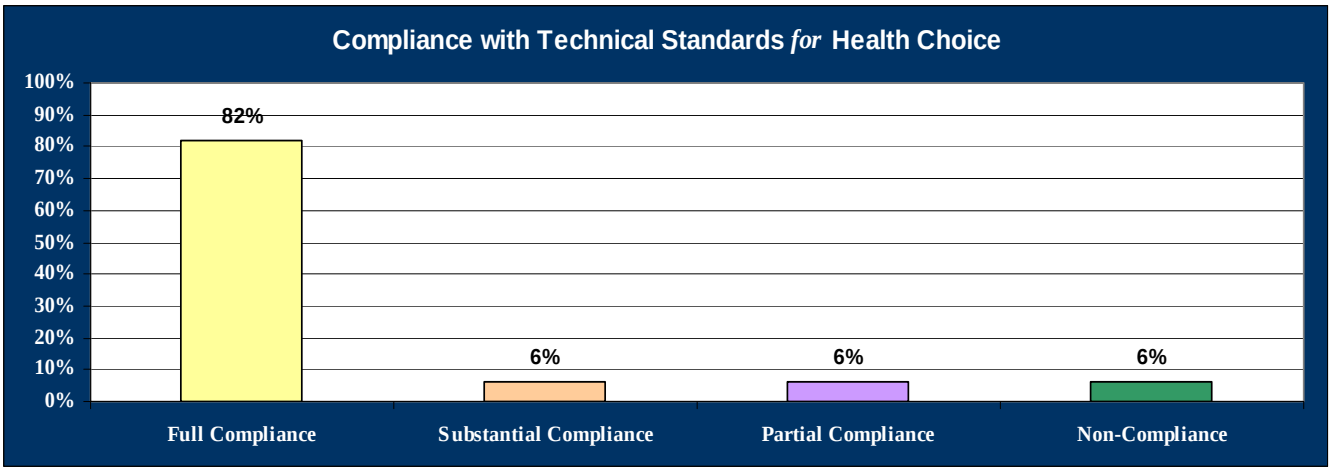
This section is not applicable because Care1st had not been a contractor long enough to include information for the AHCCCS-mandated Diabetes Management and Children's Dental PIPs.

Health Choice Arizona (Health Choice)

Compliance with Standards (Operational and Financial Review)

Figure 3-9 shows the Health Choice percentage of compliance with the technical standards selected for review in CY 2005–2006. The percentages of the standards in Full Compliance, Substantial Compliance, Partial Compliance, and Non-Compliance are shown separately, at 82 percent for Full Compliance and 6 percent for each of the remaining three categories of scores.

Figure 3-9—Compliance with Technical Standards *for* Health Choice



When interpreting the information in Figure 3-9, the difference between at least Partial Compliance and Full Compliance reflects a scenario in which the health plan seems to know the intent of the technical standards but is not fully achieving compliance. This scenario contrasts with Non-Compliance, which indicates that the health plan might not understand the intent of the technical standards. In the first case (i.e., understanding but not fully achieving compliance with the technical standards), the health plan might make large strides in attaining Full Compliance with relatively little effort. Moving a technical standard from Non-Compliance to Full Compliance, however, might require technical assistance and other activities, such as those delineated in the section on opportunities for improvement and recommendations. Importantly, however, the percentage of standards in Non-Compliance, at 6 percent, was only two-thirds of the statewide average of 9 percent. Given this overall pattern (i.e., relatively high Full Compliance and low Non-Compliance scores), compliance with technical standards was seen as an overall strength for the plan for most of the categories of standards.

Nonetheless, this overall pattern of results can obscure opportunities for improvement for specific categories of standards. Figure 3-10 shows the extent of compliance for each of the major areas within the technical standards. The figure highlights both areas of strength and opportunities for improvement. In each category, the figure shows the level of compliance with the technical standards based on Full Compliance, Substantial Compliance, Partial Compliance, and Non-Compliance.

Figure 3-10—Categorized Levels of Compliance with Technical Standards *for* Health Choice

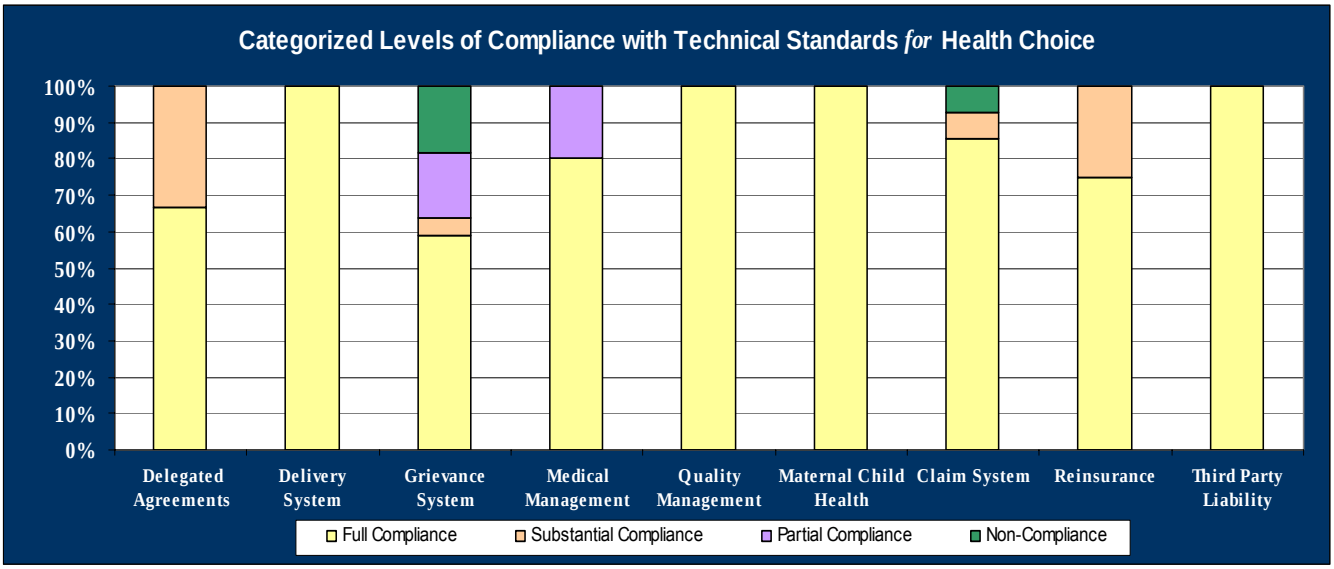


Figure 3-10 shows Full Compliance with each of the standards associated with Delivery System, Quality Management, Maternal and Child Health, and Third Party Liability, representing four of the nine categories of technical standards and 38 percent of the total number of standards reviewed. The figure also shows that Delegated Agreements and Reinsurance could be in Full Compliance with relatively little work because the standards not in Full Compliance were in Substantial Compliance.

Figure 3-10 also shows the Grievance System technical standards in about 60 percent Full Compliance and almost 20 percent Non-Compliance. The figure also suggests a high-priority opportunity for improvement in the 20 percent of the Medical Management standards in Partial Compliance.

On balance, the health plan achieved a higher rate of Full Compliance than the statewide average. When Substantial Compliance was included, the health plan scored exceptionally well. Only two standards, Grievance System and Claims System, had standards in Non-Compliance. The health plan should be commended for exceptional performance in complying with the technical standards.

CAPs for Compliance with Standards

Table 3-8 presents each of the categories of technical standards reviewed, the number of CAPs required, each category's percentage of all CAPs, the number of technical standards in each category, and the percentage of technical standards with a required CAP for each category.

The data in the table support the findings from Figure 3-10. The four categories of standards at 100 percent Full Compliance had no required CAPS. Grievance System required 10 CAPS, which represented 67 percent of the plan's required CAPS across the categories reviewed and 45 percent of the standards within Grievance System. Although all standards that were not in Full Compliance could be improved, the standards associated with Grievance System clearly showed the most room for improvement.

Table 3-8—CAP Overview *for* Health Choice				
Categories of Technical Standards	**Number of CAPs**	**Percent of Total CAPs**	**Total Number of Standards**	**CAPs as a Percent of Standards**
Delegated Agreements	1	7%	6	17%
Delivery System	0	0%	11	0%
Grievance System	10	67%	22	45%
Medical Management	1	7%	5	20%
Quality Management	0	0%	3	0%
Maternal and Child Health	0	0%	7	0%
Claims System	2	13%	14	14%
Reinsurance	1	7%	4	25%
Third Party Liability	0	0%	10	0%
Total	**15**	**100%**	**82**	**18%**

Overall, Table 3-8 shows that 18 percent of the reviewed technical standards required a CAP. Statewide, the rate was 26 percent. This finding supports the findings from Figure 3-9 and Figure 3-10, which suggest that compliance with the technical standards was an area of strength for Health Choice. The findings also suggested, however, that Grievance System was an opportunity for improvement, accounting for 67 percent of all of the health plan's required CAPS and 45 percent of the Grievance System standards requiring a CAP.

Performance Measure Review

Table 3-9 shows the separate performance measures for the two most recent time periods, along with the statistical significance for each of the changes in rates over time. Additionally, the table presents the minimum AHCCCS performance standards and whether a CAP was required.

Table 3-9—Performance Measurement Program *for* Health Choice			
Performance Measure	Previous Measurement Period[1]	Actual Performance for Oct. 1, 2004, to Sept. 30, 2005	Minimum AHCCCS Performance Standard
Children's Access to PCPs[2]	76.4%	76.9%	79%
Adult's Access to Preventive/Ambulatory Health Services[2]	77.4%	77.9%	80%
Breast Cancer Screening[2,3]	42.2%	42.2%	57%
Cervical Cancer Screening[2,4]	54.1%	57.4%*	61%
Timeliness of Prenatal Care[4]	**63.5%**	**(62.3%)**	62%
Childhood Immunization—4 DTaP	74.2%	82.6%*	83%
Childhood Immunization—3 IPV	85.5%	**93.0%***	89%
Childhood Immunization—1 MMR	**92.0%**	**92.1%**	90%
Childhood Immunization—3 HiB	**82.2%**	(74.3%)*	76%
Childhood Immunization—3 HBV	67.2%	**87.0%***	82%
Childhood Immunization—1 VZV	**84.6%**	**(81.8%)**	77%
Childhood Immunization—DTP, IPV, & MMR (4:3:1 Series)	70.7%	**80.4%***	80%
Childhood Immunization—DTP, IPV, MMR, HIB, & HBV (4:3:1:3:3 Series)	50.1%	62.1%*	70%

Notes:

Bolded rates exceed the minimum AHCCCS performance standard.

Nonbolded rates in the current measurement cycle require a CAP.

() Parentheses for current performance indicate a decrease from the previous measurement cycle.

* Statistically significant change from the previous measurement period at $p \leq .05$.

[1] Children's Access to PCPs and Adult's Access to Preventive/Ambulatory Health Services performance measures are measured and reported annually. All other performance measures are measured and reported on a rotating basis to allow health plans an intervention year between reporting periods.

[2] AHCCCS changed the methodology for collecting data and used a data warehouse to gather rate information. In order to have valid comparisons with data collected using the new process, AHCCCS used the data warehouse to recalculate rates for the previous year using the current methodology. Therefore, the rates in this report cannot be directly compared with the rates detailed in the 2006 EQRO report.

[3] The previous remeasurement period for Breast Cancer Screening was Oct. 1, 2002, through Sept. 30, 2004. The current measurement period is Oct. 1, 2003, through Sept. 30, 2005.

[4] The previous remeasurement period for Cervical Cancer Screening and Timeliness of Prenatal Care was Oct. 1, 2003, through Sept. 30, 2004.

The bolded rates show that the plan increased the number of measures exceeding the minimum AHCCCS performance standards from four to six, leaving seven nonbolded rates requiring CAPs. Three of the 13 rates (i.e., Timeliness of Prenatal Care and Childhood Immunizations—3 HiB and 1 VZV) declined between measurement periods. The rate for Childhood Immunization—3 HiB declined by a statistically significant amount ($p \leq .05$) and dropped below the AHCCCS minimum

performance standard. The rate for six of the performance measures improved by a statistically significant amount ($p \leq .05$) between the two measurement cycles. While the rates for Timeliness of Prenatal Care and Childhood Immunization—1 VZV both decreased, the current rates exceeded the minimum AHCCCS performance standards and neither of the rates decreased by a statistically significant amount (i.e., $p \leq .05$).

Performance Measures—CAPs

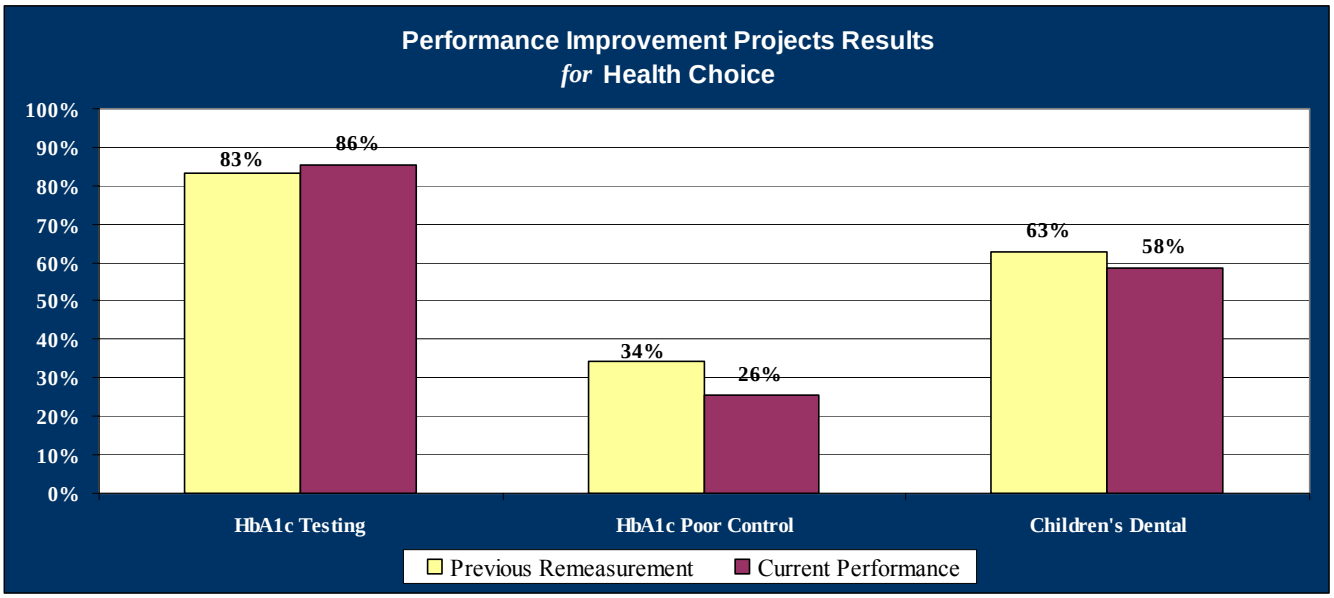
Table 3-9 shows that 7 of the 13 performance measures (i.e., 54 percent) required a CAP by not reaching the AHCCCS minimum performance standards. Although the number of measures that exceeded the minimum standard increased from 4 of the 13 (i.e., 31 percent) performance measures reviewed to 6 of the 13 (i.e., 46 percent) in the current measurement cycle, the majority of the performance measures still required a CAP and represented an overarching opportunity for improvement for the health plan.

Review of PIPs

Figure 3-11 presents the results of Health Choice's two PIPs, adult diabetes management and children's oral health. The figure shows improvement in both the measures of adult diabetes management—adjusting for the reverse nature of HbA1c Control, for which lower rates indicate better care and a decrease in performance— and a decrease in the rate for Children's Dental.

The rates for the two diabetes indicators were relatively high from a national perspective. HbA1c testing was above the national 75th percentile HEDIS Medicaid rate of 84.1 percent. The HbA1c poor control measure indicated improvement, exceeding the HEDIS 90th percentile rate. The children's dental rate decreased from 63 percent to 58 percent.

Figure 3-11—PIP Results *for* Health Choice



For the adult diabetes management measures, the improvements in rates appeared to be the result of targeted interventions. As part of its final evaluation for the PIP, the plan reported that the improvement occurred as a result of interventions that included provider education offered through newsletters, the plan Web site, and special initiatives; and member education provided through articles in member newsletters, routine mailings consisting of informational letters and the diabetic booklet, and the plan Web site information.

As part of its evaluation for the Children's Dental PIP, the plan reported numerous provider and member interventions to improve the dental rate. Member interventions included dental recall reminder mailings, dental outreach events, and member education. Provider interventions included network development and expansion, primary care provider (PCP) education, and providing PCPs with lists of members who were noncompliant with the dental program. Health Choice reported that increasing access to care (by expanding the provider network) was the most effective intervention, and sending noncompliant letters to PCPs was the second-most-effective intervention to increase children's dental visit rates. Nonetheless, these interventions, in and of themselves, cannot be assessed as sufficient because the rate fell by a statistically significant 4.3 percentage points, based on the documentation provided for the review.

Strengths, Opportunities for Improvement, and Recommendations for Health Choice

The next three sections discuss: (1) compliance with standards, (2) performance measures, and (3) PIPs. Each of these three sections presents the strengths found in the documentation provided to HSAG, opportunities for improvement, and recommendations.

Compliance with Standards (Operational and Financial Review)

Strengths

The plan's overall performance on the review of compliance with standards was a recognized strength. Health Choice was in full compliance for 82 percent of the technical standards, overall, and for all of the standards in the following individual categories: Delivery System, Quality Management, Maternal and Child Health, and Third Party Liability. As a result, relatively little effort should be required to bring the standards associated with Delegated Agreements and Reinsurance into Full Compliance because the standards that were not in Full Compliance were in Substantial Compliance.

Opportunities for Improvement and Recommendations

The standards associated with Grievance System showed the greatest opportunity for improvement. The current review included 22 standards that covered several aspects of grievance processing and reporting. Appropriate grievance systems can be an important source of information about areas of need for quality improvement activities, and appropriately structured and responsive grievance systems can markedly improve member satisfaction. Grievance systems are also important for transparency, which is fundamental to timely access to quality care, as well as to quality improvement.

Recommendations: The plan should consider initiating a comprehensive evaluation of its grievance system structure and processes that could include flow-charting both current and ideal processes to identify areas of performance vulnerability and opportunities to strengthen both performance and checks-and-balances systems of monitoring. Ideally, the evaluation would identify the factors that are contributing to the failure to fully comply with requirements (i.e., incomplete or unclear policies and procedures, staff performance such as failure to perform required actions within required time frames or failure to document the actions, and failure of the plan to conduct sufficiently detailed and frequent monitoring, etc.). The plan should also consider identifying opportunities to increasingly automate systems for logging and tracking information and actions related to the processing of grievances. For example, Technical Standard GS5 states: "The Health Plan provides the member written notice of the reason for the decision to extend the timeframe." This standard examined standing policy and the methods implemented for complying with the requirement. The standard was scored as noncompliant. This would be an excellent opportunity for the plan to automate logging and tracking of the timelines and required actions (i.e., sending a notice requesting an extension that includes the reason) and for auto-generating the notices with the reason for the extension built in as a required field, if these methods are not already in place. Additional opportunities for improvement were in the areas of reporting utilization data and information to the Quality Management Committee. The plan should also consider convening one or more cross-departmental meetings devoted to a detailed and comprehensive review of the key information and data that are currently and ideally should be collected and reported through the quality committees. Enhanced reporting processes would allow the plan to more tightly and comprehensively monitor performance across key aspects of the organization and to assess the impact of interventions the plan uses to improve compliance with the technical standards, such as the Grievance System standards.

Performance Measure Review

Strengths

The six performance measures that exceeded the minimum AHCCCS performance standards were a recognized strength for the health plan. These measures included: Timeliness of Prenatal Care and Childhood Immunization—3 IPV, 1 MMR, 3 HBV, 1 VZV, and DTP, IPV, & MMR (4:3:1 Series). In addition, the improvement in the number of measures exceeding the minimum AHCCCS performance standards (i.e., from four in the previous measurement period to six) is commendable, as is the improvement in five of the seven measures that still did not meet or exceed the minimum AHCCCS performance standards.

Opportunities for Improvement and Recommendations

The seven measures not reaching the minimum AHCCCS performance standards each represented an opportunity for improvement. These measures were: Children's Access to PCPs, Adult's Access to Preventive/Ambulatory Health Services, Breast Cancer Screening, Cervical Cancer Screening, and Childhood Immunization—4 DTaP, 3 HiB, and DTP, IPV, MMR, HIB, & HBV (4:3:1:3:3 Series).

Children's Access to PCPs can be more difficult to improve than many other measures. One contributing factor may be that for appointments for children, the schedules of both the child and the person bringing the child to the PCP are involved, whereas appointments for adults typically involve just the schedule of the adult visiting the PCP on his or her own.

Recommendation: In addition to identifying probable causes for failing to meet the AHCCCS minimum performance standard and implementing targeted interventions to improve performance, the plan should consider comparing the hours of provider availability and the hours of available public transportation with the times of the day and days of the week that working parents whose children are eligible for Medicaid services can typically bring their children to see a PCP. If indicated by the analysis, the plan should require increased provider availability in the evenings and on weekends.

The health plan might find that the changes needed to improve access for children might also be effective for improving the rate for Adult's Access to Preventive/Ambulatory Health Services. Members need to make and keep appointments in order for physicians to provide appropriate preventive/ambulatory care.

Recommendation: In addition to assessing the availability of physician appointments in the evening and weekends to accommodate working adults, the plan should consider implementing or enhancing physician and member reminder systems, if they are not already in place.

Breast and Cervical Cancer Screening might require very different interventions (i.e., changes) to improve their rates. Quite often, women must make additional appointments for these screenings, and typically with a provider other than their PCP, and in a different location.

Recommendation: In addition to identifying other probable causes for the rates failing to meet the AHCCCS minimum performance standard and implementing targeted interventions, the plan should

consider exploring opportunities and strategies to provide one or more of the required services during any type of office visit, and consolidating radiology and the office visit as though they were a single appointment. In addition, if not currently in place, automated notices to physicians identifying members due for the required screenings and automated reminders and educational information sent to members may positively impact the performance rates.

Recommendation: In addition to the above recommendations, the plan should consider conducting a comprehensive provider and member profiling project. For providers, the project would focus on identifying patterns of less-than-acceptable performance by individual providers and provider group practices related to each of the performance measures. For members, the project would focus on any clear patterns of member characteristics for those not receiving the appropriate screenings, immunizations, etc., compared with those who are. Specific and targeted interventions could then focus on providers with the poorest performance and members who are not participating in their own preventative health care.

Review of PIPs

Strengths

The rates for the two diabetes indicators showed that HbA1c testing was above the national 75th percentile HEDIS Medicaid rate of 84.1 percent. The HbA1c control rate exceeded the HEDIS 90th percentile after adjusting for the reversed structure of the measure. For these reasons, the adult diabetes management PIP was considered a strength for the health plan.

Opportunities for Improvement and Recommendations

Because of the statistically significant decline between the two most recent measurement periods and failure to sustain improvement, the Children's Dental PIP is an opportunity for improvement. During the third and subsequent measurement periods, the PIP is at the Sustained Improvement activity. Quoting from the CMS protocol on validating PIPs:[3-3]

> Real change results from changes in the fundamental processes of health care delivery. Such changes should result in sustained improvements. In contrast, a spurious "one time" improvement can result from unplanned accidental occurrences or random chance. If real change has occurred, the MCO/PIHP should be able to document sustained improvement.

A statistically significant decline, such as the one seen by the health plan (i.e., $p < .001$) is evidence that suggests that real change might not have taken place. If the health plan believes that the decline could be explained by external events (e.g., substantively large changes in the network), statistical or other adjustment processes should have been used by the PIP to present results that the plan believes would be more appropriately comparable.

[3-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. Validating performance improvement projects: A protocol for use in conducting Medicaid external quality review activities. *Protocols for External Quality Review of Medicaid Managed Care Organizations and Prepaid Inpatient Health Plans.* Final Protocol, Version 1.0, May 1, 2002. Available at: http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/ , pg. 19.

Recommendation: The health plan should consider conducting a root cause analysis to identify one or more intervening variables that might have been responsible for the significant drop in the rate. The plan should then implement the targeted changes needed to bring performance back to at least the level attained during the previous measurement period and, ideally, improve that level of performance.

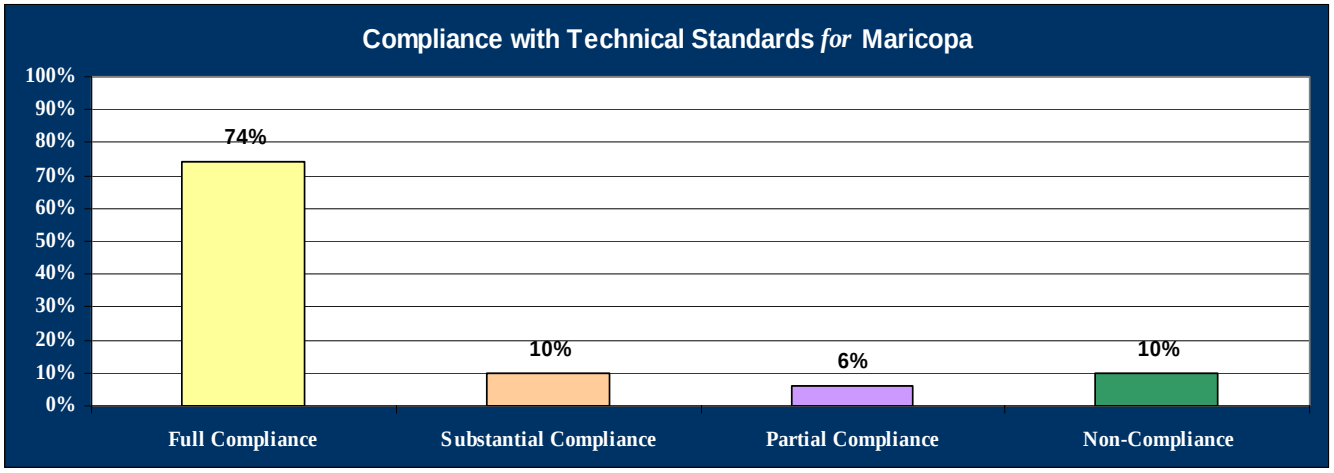
Maricopa Health Plan (Maricopa)

On October 1, 2005, University Physicians Health Plans (UPHP) assumed the management of Maricopa Health Plan. Recommendations in this section that are based on either current levels of performance or on changes between the current and most recent measurement periods should, therefore, be weighed in light of the shift in management and the challenges that it brings. Conversely, areas that are recognized or highlighted as apparent strengths might no longer be strengths or might not be sustained due to the same variables associated with changes in management.

Compliance with Standards (Operational and Financial Review)

Figure 3-12 shows Maricopa's percentage of compliance with the technical standards selected for review in CY 2005–2006. The percentages of the standards in Full Compliance, Substantial Compliance, Partial Compliance, and Non-Compliance are shown separately.

Figure 3-12—Compliance with Technical Standards *for* Maricopa



When interpreting the information in Figure 3-12, the difference between at least Partial Compliance and Full Compliance reflects a scenario in which the health plan seems to know the intent of the technical standards but is not fully achieving compliance. This scenario contrasts with Non-Compliance, which indicates that the health plan might not understand the intent of the technical standards. In the first case (i.e., understanding but not fully achieving compliance with the technical standards), the health plan might make large strides in attaining full compliance with relatively little effort. Moving a technical standard from Non-Compliance to Full Compliance, however, might require technical assistance and other activities, such as those delineated in the section on opportunities for improvement and recommendations. The health plan's Non-Compliance rate of 10 percent was just above the statewide average of 9 percent.

Figure 3-13 shows the extent of compliance for each of the major areas within the technical standards. The figure highlights both areas of strength and opportunities for improvement. In each category, the figure shows the level of compliance with the technical standards based on Full Compliance, Substantial Compliance, Partial Compliance, and Non-Compliance.

Figure 3-13—Categorized Levels of Compliance with Technical Standards *for* Maricopa

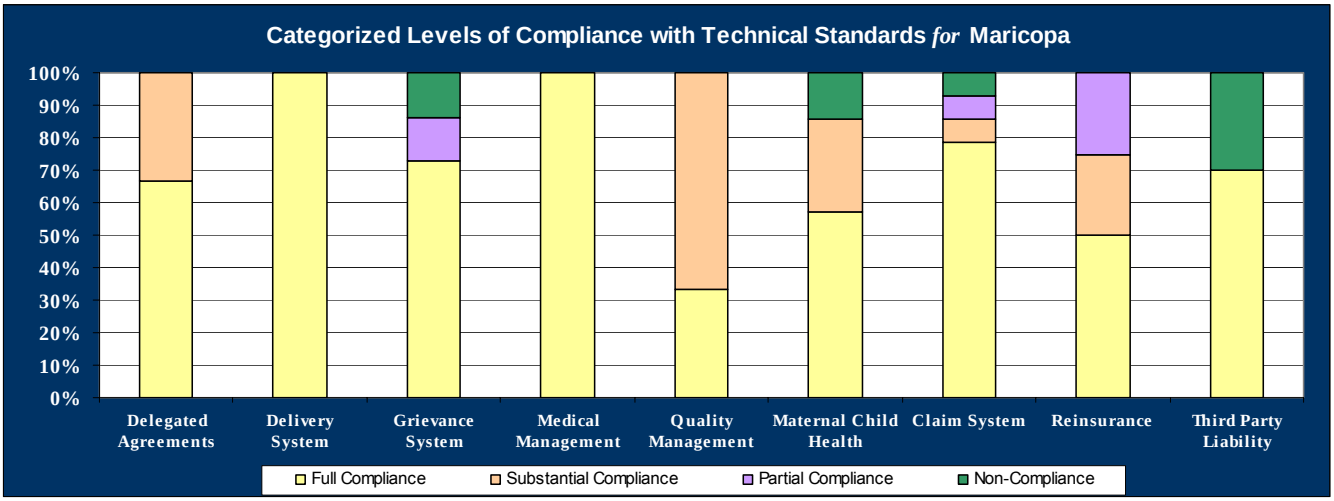


Figure 3-13 shows Full Compliance with each of the standards associated with Delivery System and Medical Management. The figure also shows Full or Substantial Compliance with Delegated Agreements and Quality Management, although Quality Management has two of its three technical standards scored as Substantially Compliant and, therefore, required CAPs.

Figure 3-13 also shows the Grievance System technical standards in about 70 percent Full Compliance and in almost 14 percent Non-Compliance. The single standard in Non-Compliance for Maternal and Child Health represented 14 percent of that category's standards. The figure suggests high-priority opportunities for improvement in Third Party Liability, where 30 percent of standards were in Non-Compliance.

CAPs for Compliance with Standards

Table 3-10 presents each of the categories of technical standards reviewed, the number of CAPs required, each category's percentage of all CAPs, the number of technical standards in each category, and the percentage of technical standards with a required CAP for each category.

Table 3-10—CAP Overview *for* Maricopa				
Categories of Technical Standards	Number of CAPs	Percent of Total CAPs	Total Number of Standards	CAPs as a Percent of Standards
Delegated Agreements	2	9%	6	33%
Delivery System	0	0%	11	0%
Grievance System	7	30%	22	32%
Medical Management	0	0%	5	0%
Quality Management	2	9%	3	67%
Maternal and Child Health	3	13%	7	43%
Claims System	4	17%	14	29%
Reinsurance	2	9%	4	50%
Third Party Liability	3	13%	10	30%
Total	**23**	**100%**	**82**	**28%**

The table shows that neither Delivery System nor Medical Management required a CAP. The health plan is commended for its successful performance on the standards in these categories. Conversely, Grievance System was responsible for 30 percent of the overall required CAPs and had CAPs required for 32 percent of the Grievance System standards. Quality Management, Maternal and Child Health, and Reinsurance all showed proportionately high rates of required CAPs. Overall, 28 percent of the technical standards required a CAP.

Performance Measure Review

Table 3-11 shows the separate performance measures for the two most recent time periods, along with the statistical significance for each of the changes in rates over time. Additionally, the table presents the minimum AHCCCS performance standards and whether a CAP was required.

Table 3-11—Performance Measurement Program *for* Maricopa			
Performance Measure	Previous Measurement Period[1]	Actual Performance for Oct. 1, 2004, to Sept. 30, 2005	Minimum AHCCCS Performance Standard
Children's Access to PCPs[2]	67.4%	69.3%*	79%
Adult's Access to Preventive/Ambulatory Health Services[2]	73.3%	74.2%	80%
Breast Cancer Screening[2,3]	52.7%	(50.2%)	57%
Cervical Cancer Screening[2,4]	49.9%	55.8%*	61%
Timeliness of Prenatal Care[4]	57.5%	61.4%	62%
Childhood Immunization—4 DTaP	**90.1%**	**(84.6%)**	83%
Childhood Immunization—3 IPV	**96.2%**	**(95.6%)**	89%
Childhood Immunization—1 MMR	**96.2%**	**(93.9%)**	90%
Childhood Immunization—3 HiB	**92.0%**	**(88.6%)**	76%
Childhood Immunization—3 HBV	**90.9%**	**(84.6%)***	82%
Childhood Immunization—1 VZV	**94.3%**	**(89.9%)**	77%
Childhood Immunization—DTP, IPV, & MMR (4:3:1 Series)	**88.2%**	**(84.6%)**	80%
Childhood Immunization—DTP, IPV, MMR, HIB, & HBV (4:3:1:3:3 Series)	**77.6%**	**(72.8%)**	70%

Notes:

Bolded rates exceed the minimum AHCCCS performance standard.

Nonbolded rates in the current measurement cycle require a CAP.

() Parentheses for current performance indicate a decrease from the previous measurement cycle.

* Statistically significant change from the previous measurement period at $p \leq .05$.

[1] Children's Access to PCPs and Adult's Access to Preventive/Ambulatory Health Services performance measures are measured and reported annually. All other performance measures are measured and reported on a rotating basis to allow health plans an intervention year between reporting periods.

[2] AHCCCS changed the methodology for collecting data and used a data warehouse to gather rate information. In order to have valid comparisons with data collected using the new process, AHCCCS used the data warehouse to recalculate rates for the previous year using the current methodology. Therefore, the rates in this report cannot be directly compared with the rates detailed in the 2006 EQRO report.

[3] The previous remeasurement period for Breast Cancer Screening was Oct. 1, 2002, through Sept. 30, 2004. The current measurement period is Oct. 1, 2003, through Sept. 30, 2005.

[4] The previous remeasurement period for Cervical Cancer Screening and Timeliness of Prenatal Care was Oct. 1, 2003, through Sept. 30, 2004.

The bolded rates show that the plan maintained the number of measures exceeding the minimum AHCCCS performance standards at eight, leaving five nonbolded rates that require CAPs. Nine of the 13 rates declined between measurement periods, but only Childhood Immunizations—3 HBV decreased by a statistically significant amount ($p \leq .05$). The nine declining rates included all eight rates that exceeded the minimum AHCCCS performance standards. Lastly, rates for only two of the

performance measures improved by a statistically significant amount ($p \leq .05$) between the two measurement cycles (i.e., Children's Access to PCPs and Cervical Cancer Screening).

When these findings are jointly assessed, one possible conclusion is that the ongoing data issues experienced by Maricopa may have been a significant factor in the lower performance measure rates. Another possible conclusion is that limited resources may have been invested in performance measures with the most need for improvement and not where results were already exceeding the minimum AHCCCS performance standards. Nonetheless, quality improvement includes sustaining the delivery of timely access to quality care. At a minimum, Maricopa should analyze the reasons for the declines in performance measure rates.

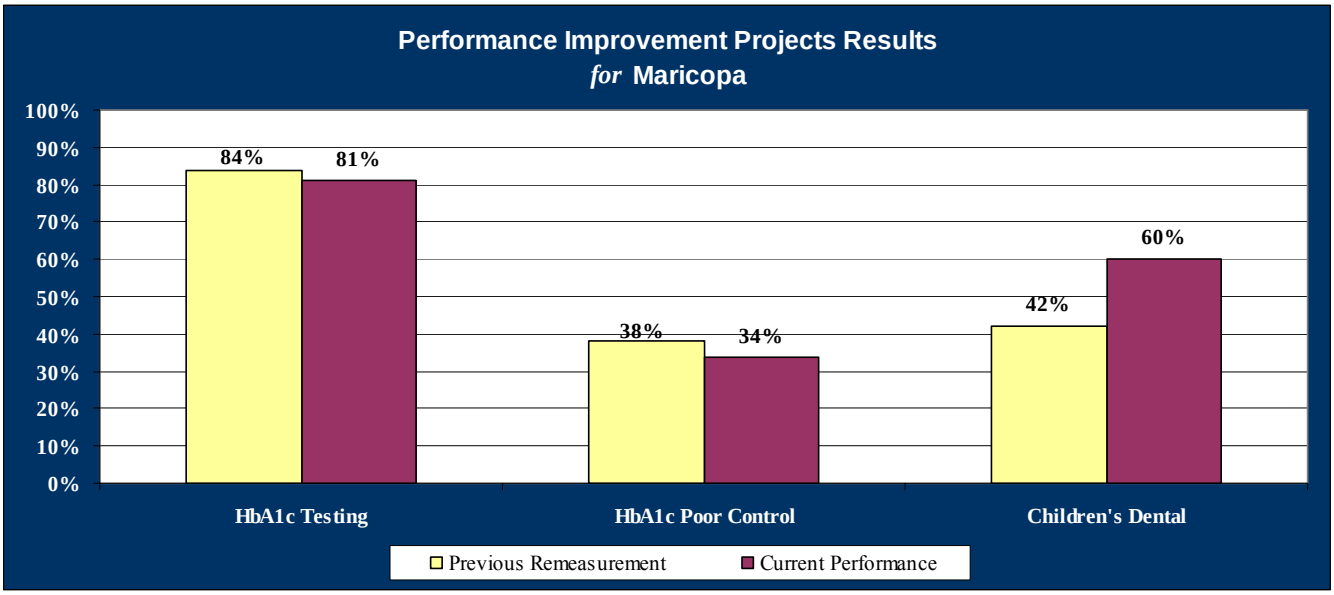
Performance Measures—CAPs

Table 3-11 shows that 5 of the 13 performance measures (i.e., 38 percent) required a CAP by not reaching the minimum AHCCCS performance standards. Five required CAPs was also the statewide average (see Table 3-3). Overall, the number of measures that exceeded the minimum AHCCCS performance standards remained unchanged at eight (i.e., 62 percent).

Review of PIPs

Figure 3-14 presents the results of Maricopa's two PIPs, adult diabetes management and children's oral health. The figure shows mixed results for adult diabetes management and an increase in performance for Children's Dental from 42 percent to 60 percent.

Figure 3-14—PIP Results *for* Maricopa



The rates for the two diabetes indicators were relatively high from a national perspective. HbA1c testing was between the 50th and 75th HEDIS Medicaid percentile rates. The HbA1c poor control measure indicated improvement and was between the 75th and 90th HEDIS Medicaid percentile rates after adjusting for the reversed structure of the measure, for which lower rates indicate better care.

The increase in the Children's Dental rate, from 42 percent to 60 percent, was substantively large and commendable. In conjunction with the already relatively high rates for the adult diabetes management indicators, this finding also suggested that limited resources may have been applied where improvement was needed most. Nonetheless, no explanation was offered beyond the following for the adult diabetes management PIP.

> "University Physicians Health Plans (UPHP) assumed management of Maricopa Health Plan on October 1, 2005. The results contained in this report occurred prior to UPHP management. Consequently, information regarding the barriers identified, the interventions implemented and any changes in methodology based on their analysis is unavailable to the current management."

For the Children's Dental PIP, all that was stated was:

> "University Physicians Health Plans (UPHP) assumed management of Maricopa Health Plan on October 1, 2005. The results contained in this report occurred prior to UPHP management."

Strengths, Opportunities for Improvement, and Recommendations for Maricopa

The next three sections discuss: (1) compliance with standards, (2) performance measures, and (3) PIPs. Each of these three sections presents the strengths found in the documentation provided to HSAG, opportunities for improvement, and recommendations.

Compliance with Standards (Operational and Financial Review)

Strengths

The compliance review showed Full Compliance with each of the standards associated with Delivery System and Medical Management. These categories of technical standards were, therefore, considered strengths for the health plan.

Opportunities for Improvement and Recommendations

The number and proportion of technical standards in Substantial Compliance increases the relative number of CAPs but indicates that less improvement may be needed to bring the standards up to Full Compliance compared with standards in Partial Compliance or Non-Compliance. Performance on standards for Grievance System, Maternal and Child Health, and Third Party Liability had the clearest opportunities for improvement.

For Grievance System, the current review included 22 associated standards covering several aspects of grievance processing and reporting. Appropriate grievance systems can be an important source of information about areas of need for quality improvement activities, and appropriately structured and responsive grievance systems can markedly improve member satisfaction. Grievance systems are also important for transparency, which is fundamental to timely access to quality care, as well as to quality improvement.

Recommendation: The plan should consider initiating a comprehensive evaluation of its grievance system structure and processes that could include flow-charting both current and ideal processes to identify areas of performance vulnerability and opportunities to strengthen both performance and checks-and-balances systems of monitoring. Ideally, the evaluation would identify the factors that are contributing to the failure to fully comply with requirements (i.e., incomplete or unclear policies and procedures, staff performance such as failure to perform required actions within required time frames or failure to document the actions, and failure of the plan to conduct sufficiently detailed and frequent monitoring, etc.). The plan should also consider identifying opportunities to increasingly automate systems for logging and tracking information and actions related to the processing of grievances. For example, Technical Standard GS5 states: "The Health Plan provides the member written notice of the reason for the decision to extend the timeframe." This standard examined standing policy and the methods implemented for complying with the requirement. The standard was scored as Non-Compliant. This would be an excellent opportunity for the plan to automate logging and tracking of the timelines and required actions (i.e., sending a notice requesting an extension that includes the reason) and for auto-generating the notices with the reason for the extension built in as a required field, if these interventions are not already in place. The plan may, in fact, want to prioritize those interventions that, if not already operational, can be accomplished through automation of processes, correspondence, logging/tracking timelines and actions required and taken, prompts and cueing of required actions, and the use of required fields for mandatory actions, documentation, and information provided in correspondence to the members.

For Maternal and Child Health, five of the seven standards within the category involve compliance with EPSDT requirements. A sixth standard reviews the training and use of the PEDS tools, which has ramifications for physician practice, member health, and State monitoring of children's services. The only standard that is not directly related solely to children's health assesses the extent to which services are coordinated with other agencies, according to State and federal requirements. These standards set minimum levels of care to ensure that some of the most potentially vulnerable plan members (i.e., children) have timely access to quality care. Furthermore, children are less likely to complain about care than adults, and adults are often not sufficiently versed in children's health care needs and guidelines to be the most appropriate advocates for their children.

Recommendation: The plan should consider conducting a detailed and comprehensive side-by-side comparison of its EPSDT policies and guidelines with the associated State and federal requirements to assess the degree of completeness and clarity of the plan policies and guidelines. The plan should then revise the policies and guidelines where needed to be consistent and fully compliant with the State and federal requirements. The plan should also consider appointing a staff person or designated quality body to ensure that the plan remains current in its knowledge of any changes to State and federal requirements, and that the plan's documents are revised accordingly.

The three CAPs required for Third Party Liability related to the processing and timing of third-party liability claims. For two of the standards (i.e., TPL 6 and TPL 7), six of the nine health plans were scored as fully compliant with the standards' requirements. These two standards would appear to be clear enough for the health plan to develop appropriate policies and procedures for its internal processes. For the third standard (i.e., TPL 9: "The Health Plan contacts AHCCCS prior to negotiating a settlement on a total plan casualty case to determine if there has been reinsurance or fee-for-service payments made by AHCCCS."), three of the nine health plans were scored as fully

compliant. Although the health plans were less successful statewide with this standard than with the other two, again, the intent of the standard appeared to be very clear.

Recommendation: As with the previous recommendation, the health plan should consider a detailed and comprehensive review of its internal policies and procedures to ensure that they include all applicable AHCCCS requirements and the processes to be followed for complying with them. The health plan should also consider building into its procedures/protocols electronic prompts for required actions (i.e. notifying AHCCCS before negotiating settlements).

Performance Measure Review

Strengths

An objective strength identified from the performance measure review was the finding that the measures with rates that started below the minimum AHCCCS performance standards were, for the most part, the measures that increased (i.e., four of the five measures). An assessed strength was the uniformity and the frequency by which the selected childhood immunizations were being delivered. Although the rates decreased between measurement periods, every tracked childhood immunization rate still exceeded the AHCCCS minimum performance standards. It appeared that the resources and improvement activities were applied where prioritized improvement was needed most.

Opportunities for Improvement and Recommendations

There were five performance measures with rates below the minimum AHCCCS performance standards. These measures were: Children's Access to PCPs, Adult's Access to Preventive and Ambulatory Health Services, Breast Cancer Screening, Cervical Cancer Screening, and Timeliness of Prenatal Care. By having rates below the minimum AHCCCS performance standards and associated required CAPs, these measures were clear opportunities for improvement.

Children's Access to PCPs can be more difficult to improve than many other measures. One contributing factor may be that for appointments for children, the schedules of both the child and the person bringing the child to the PCP are involved, whereas appointments for adults typically involve just the schedule of the adult visiting the PCP on his or her own.

Recommendation: In addition to identifying probable causes for performance where rates did not meet the AHCCCS minimum standard and implementing targeted interventions to improve performance, the plan should consider comparing the hours of provider availability and the hours of available public transportation with the times of the day and days of the week that working parents whose children are eligible for Medicaid services can typically bring their children to see a PCP. If indicated by the analysis, the plan should require increased provider availability in the evenings and on weekends. The plan should also consider implementing or enhancing provider and member reminder notices and member informational materials.

The health plan might find that the changes needed to improve access for children could also be effective for improving the rate for Adult's Access to Preventive/Ambulatory Health Services. Members need to make and keep appointments for physicians to provide appropriate preventive/ambulatory care.

Recommendation: The health plan should consider analyzing the availability of providers in the evening and on weekends to accommodate working adults, and consider implementing or enhancing physician and member reminder systems and member informational materials

Access to breast and cervical cancer screenings has a somewhat different set of challenges for women. Quite often, women must make additional appointments for these screenings, and typically with a different provider in a different location.

Recommendation: In addition to identifying other probable causes for not meeting the minimum required rates and implementing targeted interventions, the plan should consider exploring opportunities and strategies to provide one or more of the required services during any type of office visit, and consolidating radiology and the office visit as though they were a single appointment. In addition, if not currently in place, automated notices to physicians identifying members due for the required screenings and automated reminders and educational information sent to members may positively impact the performance rates.

Recommendation: For Timeliness of Prenatal Care, the health plan should consider evaluating the availability of evening and week-end appointments to accommodate the needs of working pregnant women, and initiating or enhancing provider and member appointment reminder systems.

Recommendation: In addition to the above recommendations, the plan should consider conducting a comprehensive provider and member profiling project. For providers, the project would focus on identifying patterns of less-than-acceptable performance by individual providers and provider group practices related to each of the performance measures. For members, the project would focus on any clear patterns of member characteristics for those not receiving the appropriate screenings, immunizations, etc., compared with those who are. Specific and targeted interventions could then focus on providers with the poorest performance and members who are not participating in their own preventative health care.

Review of PIPs

Strengths

The substantively large increase in the Childhood Dental rate was a strength for the plan. Unfortunately, information on the previous interventions for the PIP was not available. This lack of information on a PIP with a rate that showed a relative increase of 43 percent and a reduction in failure rate of 31 percent could represent an unfortunate loss to accomplishing similar quality improvement efforts statewide by not being available to be shared and used as a best practice model for future improvement efforts.[3-4]

Opportunities for Improvement and Recommendations

Given the relatively high rates from a national perspective and the change in the health plan's management, no opportunities for improvement or recommendations are suggested. Nonetheless,

[3-4] The lack of available information on interventions was specifically stated only for the adult diabetes management PIP. Nonetheless, comments by the plan on interventions for the Children's Dental PIP imply a similar lack of available information.

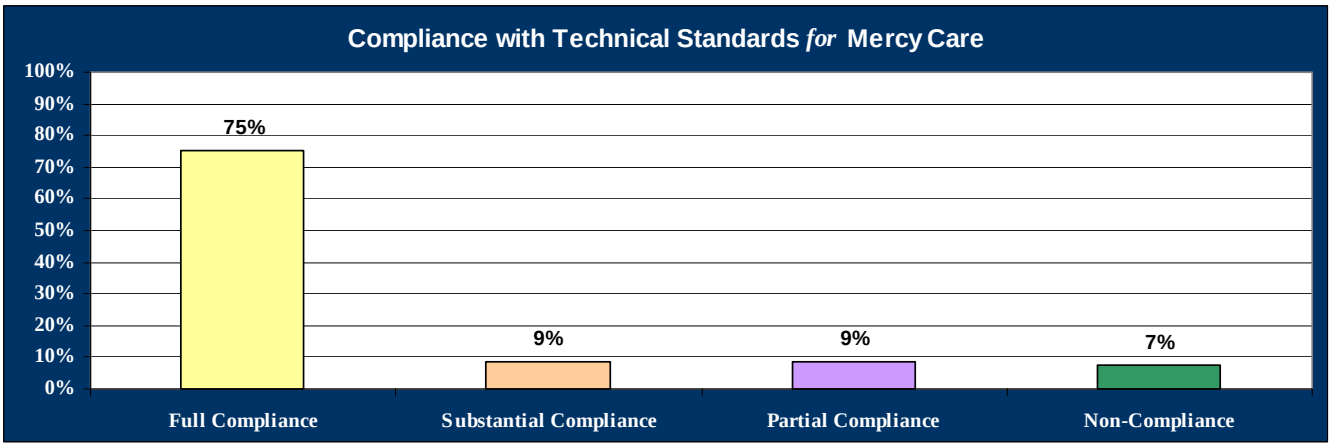
the substantial improvement in the Children's Dental PIP seems sufficiently important to want to encourage the new management of the health plan to investigate the processes and interventions that contributed to the success of the PIP.

Mercy Care Plan (Mercy Care)

Compliance with Standards (Operational and Financial Review)

Figure 3-15 shows the Mercy Care percentage of compliance with the technical standards selected for review in CY 2005–2006. The percentages of the standards in Full Compliance, Substantial Compliance, Partial Compliance, and Non-Compliance are shown separately.

Figure 3-15—Compliance with Technical Standards *for* Mercy Care Plan



When interpreting the information in Figure 3-15, the difference between at least Partial Compliance and Full Compliance reflects a scenario in which the health plan seems to know the intent of the technical standards but is not fully achieving compliance. This scenario contrasts with Non-Compliance, which indicates that the health plan might not understand the intent of the technical standards. In the first case (i.e., understanding but not fully achieving compliance with the technical standards), the health plan might make large strides in attaining Full Compliance with relatively little effort. Moving a technical standard from Non-Compliance to Full Compliance, however, might require technical assistance and other activities, such as those delineated in the section on opportunities for improvement and recommendations. The health plan's rate of Non-Compliance of 7 percent was below the statewide average of 9 percent, while standards in Substantial and Partial Compliance were each 9 percent of the total number of standards across the nine categories reviewed.

Nonetheless, this overall pattern of results can obscure strengths and opportunities for improvement for specific categories of standards. Figure 3-16 shows the extent of compliance for each of the major areas within the technical standards. The figure highlights areas of strength and areas where opportunities for improvement exist in a stacked-bar format, showing the level of compliance with the technical standards based on Full Compliance, Substantial Compliance, Partial Compliance, and Non-Compliance within each assessed category.

Figure 3-16—Categorized Levels of Compliance with Technical Standards *for* Mercy Care

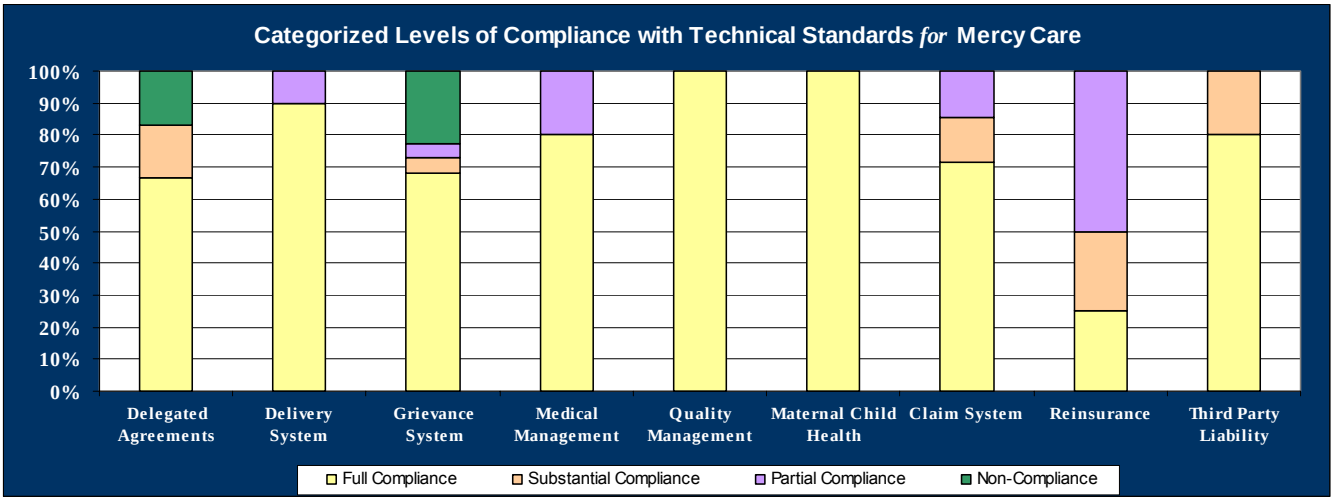


Figure 3-16 shows Full Compliance with each of the standards associated with Quality Management and Maternal and Child Health. The figure also shows Full or Substantial Compliance with Third Party Liability.

Figure 3-16 shows the Reinsurance technical standards at only 25 percent fully compliant as a result of performance on one of the four standards within the category. Delegated Agreements was scored at 17 percent Non-Compliance, also as a result of performance on one of the six standards in the category. In contrast, Grievance System had 23 percent of its standards in Non-Compliance because five of its seven technical standards were not in Full Compliance.

CAPs for Compliance with Standards

Table 3-12 shows each category of technical standards reviewed, the number of CAPs required, the percentage of CAPs in each category, the number of technical standards in each category, and the percentage of technical standards for each category with a required CAP.

Table 3-12—CAP Overview *for* Mercy Care				
Categories of Technical Standards	**Number of CAPs**	**Percent of Total CAPs**	**Total Number of Standards**	**CAPs as a Percent of Standards**
Delegated Agreements	2	9%	6	33%
Delivery System	1	5%	10	10%
Grievance System	7	32%	22	32%
Medical Management	1	5%	5	20%
Quality Management	0	0%	3	0%
Maternal and Child Health	1	5%	7	14%
Claims System	4	18%	14	29%
Reinsurance	3	14%	4	75%
Third Party Liability	3	14%	10	30%
Total	**22**	**100%**	**81**	**27%**

The table shows that none of the Quality Management standards required a CAP. Delivery System, Medical Management, and Maternal and Child Health required only one CAP each. The health plan is commended for its success in these categories. Conversely, Grievance System was responsible for 32 percent of the required CAPS and had CAPs required for 32 percent of its standards. Although Reinsurance had fewer CAPs than Claims System, Reinsurance had CAPs required for 75 percent of its standards compared with 29 percent for Claims System. Overall, 27 percent of Mercy Care's technical standards required a CAP.

Performance Measure Review

Table 3-13 shows the separate performance measures for the two most recent time periods, along with the statistical significance for each of the changes in rates over time. Additionally, the table presents the minimum AHCCCS performance standards and whether a CAP was required.

Table 3-13—Performance Measurement Program *for* Mercy Care			
Performance Measure	Previous Measurement Period[1]	Actual Performance for Oct. 1, 2004, to Sept. 30, 2005	Minimum AHCCCS Performance Standard
Children's Access to PCPs[2]	78.2%	78.8%*	79%
Adult's Access to Preventive/Ambulatory Health Services[2]	79.8%	**80.2%**	80%
Breast Cancer Screening[2,3]	48.4%	(47.3%)	57%
Cervical Cancer Screening[2,4]	56.7%	57.7%	61%
Timeliness of Prenatal Care[4]	**75.8%**	**(70.3%)***	62%
Childhood Immunization—4 DTaP	**84.9%**	**(84.3%)**	83%
Childhood Immunization—3 IPV	**92.0%**	**(91.4%)**	89%
Childhood Immunization—1 MMR	**93.6%**	**(93.4%)**	90%
Childhood Immunization—3 HiB	**87.5%**	**88.2%**	76%
Childhood Immunization—3 HBV	**89.6%**	**90.1%**	82%
Childhood Immunization—1 VZV	**83.2%**	**87.9%***	77%
Childhood Immunization—DTP, IPV, & MMR (4:3:1 Series)	**82.5%**	**82.8%**	80%
Childhood Immunization—DTP, IPV, MMR, HIB, & HBV (4:3:1:3:3 Series)	**74.5%**	**76.2%**	70%

Notes:

Bolded rates exceed the minimum AHCCCS performance standard.

Nonbolded rates in the current measurement cycle require a CAP.

() Parentheses for current performance indicate a decrease from the previous measurement cycle.

* Statistically significant change from the previous measurement period at $p \leq .05$.

[1] Children's Access to PCPs and Adult's Access to Preventive/Ambulatory Health Services performance measures are measured and reported annually. All other performance measures are measured and reported on a rotating basis to allow health plans an intervention year between reporting periods.

[2] AHCCCS changed the methodology for collecting data and used a data warehouse to gather rate information. In order to have valid comparisons with data collected using the new process, AHCCCS used the data warehouse to recalculate rates for the previous year using the current methodology. Therefore, the rates in this report cannot be directly compared with the rates detailed in the 2006 EQRO report.

[3] The previous remeasurement period for Breast Cancer Screening was Oct. 1, 2002, through Sept. 30, 2004. The current measurement period is Oct. 1, 2003, through Sept. 30, 2005.

[4] The previous remeasurement period for Cervical Cancer Screening and Timeliness of Prenatal Care was Oct. 1, 2003, through Sept. 30, 2004.

The bolded rates show that the plan increased the number of measures exceeding the minimum AHCCCS performance standards from 9 to 10, leaving 3 nonbolded rates that require CAPs. Five of the 13 rates declined between measurement periods, but only the rate for Timeliness of Prenatal Care declined by a statistically significant amount ($p \leq .05$). Four of the declining rates were above the minimum AHCCCS performance standards. Breast Cancer Screening was the only decreasing

measure with a rate that was below the minimum AHCCCS performance standard in the prior measurement period. Lastly, the rates for only two performance measures improved by statistically significant amounts ($p \leq .05$) between the two measurement cycles (i.e., (Children's Access to PCPs and Childhood Immunizations—1 VZV).

The rate for Children's Access to PCPs improved by a statistically significant amount ($p \leq .05$), however, the rate was still 0.2 percent below the minimum AHCCCS performance standard. While the increase is commendable, the health plan is encouraged to ensure, through continued focus on improvement in this area, that the rates for this measure exceed the minimum AHCCCS performance standard in the next measurement cycle.

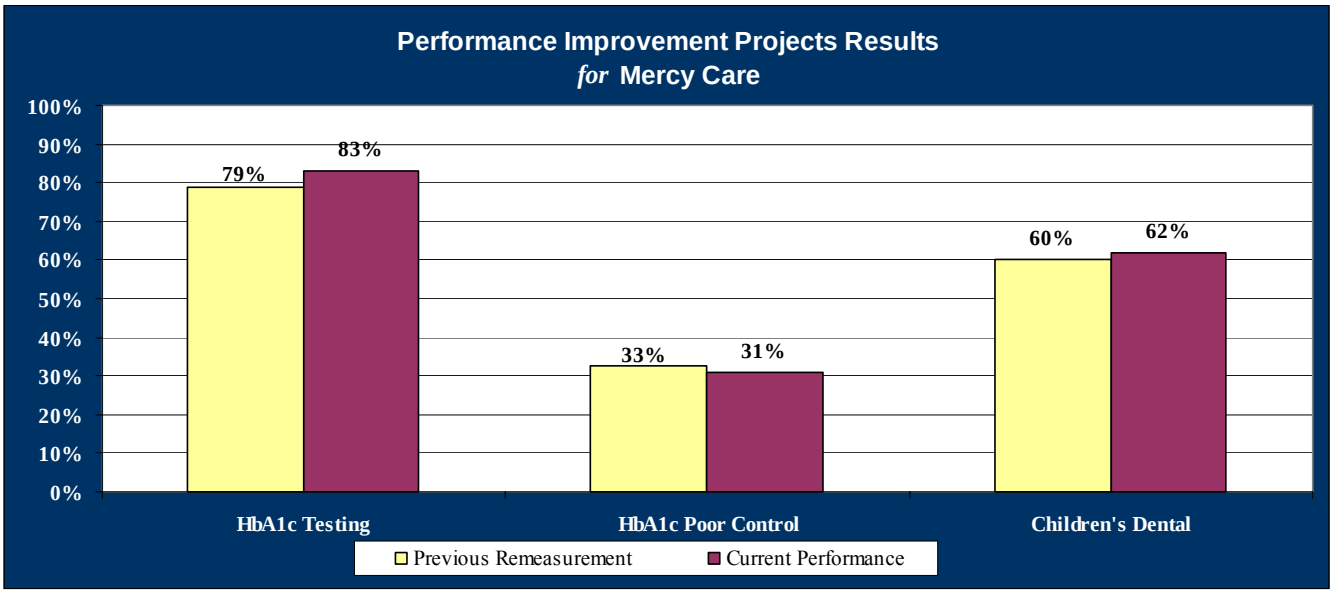
Performance Measures—CAPs

Table 3-13 shows that 3 of the 13 performance measures (i.e., 23 percent) required a CAP by not reaching the minimum AHCCCS performance standards. Overall, the number of measures that exceeded the minimum AHCCCS performance standards increased from 9 of the 13 reviewed performance measures (i.e., 69 percent) to 10 (i.e., 77 percent) in the current measurement cycle. The three measures requiring a CAP (i.e., Children's Access to PCPs, Breast Cancer Screening, and Cervical Cancer Screening) were also statewide opportunities for improvement.

Review of PIPs

Figure 3-17 presents the results of Mercy Care's two PIPs, adult diabetes management and children's oral health. The figure shows improvement in each of the measures used to assess these PIPs. The rates for the diabetes indicators were strong from a national perspective. HbA1c testing was close to the national 75th percentile HEDIS Medicaid rate of 84.1 percent. The HbA1c control measure, for which a decrease (as shown in the figure) indicates improvement, was equivalent to the HEDIS 90th percentile rate. The children's oral health measure increased from 60 percent to 62 percent.

Figure 3-17—PIP Results *for* Mercy Care



In achieving the results for the adult diabetes management PIP, Mercy Care reported that the rate of improvement occurred during the course of member- and provider-level interventions, as well as during extensive case management interventions. The case management interventions were designed to ensure that targeted diabetic members consistently received needed diabetic care. Efforts included stratifying members into categories of high, medium, and low risk. Targeted member interventions, such as educational mailings, assigning nurse case managers, telephone education, and referral to diabetes education programs, corresponded to the stratified level of risk for each member. The health plan also implemented quarterly provider reports listing diabetic members missing HbA1c tests, lipid screenings, or eye examinations. Mercy Care reported that anecdotal feedback from providers indicated that the reports were well-received and assisted providers with ensuring diabetic members received appropriate diabetes-related services.

For the Children's Dental PIP, the health plan reported that numerous provider and member interventions were implemented to improve the dental rate. Member interventions included dental reminder cards, second reminder letters, outreach calls to guardians of children, articles about oral hygiene in the member newsletters, and providing oral hygiene information at community health fairs. Provider interventions included the hiring of a full-time dental director, monitoring dental performance, reinforcing EPSDT requirements to refer members for dental treatment or preventive visits, and increasing the number of available dental providers in the network.

Strengths, Opportunities for Improvement, and Recommendations for Mercy Care

The next three sections discuss: (1) compliance with standards, (2) performance measures, and (3) PIPs. Each of these three sections presents the strengths found in the documentation provided to HSAG, opportunities for improvement, and recommendations.

Compliance with Standards (Operational and Financial Review)

Strengths

The compliance review showed Full Compliance with each of the standards associated with Quality Management and with Maternal and Child Health. These categories of technical standards were considered as strengths for the health plan. The 90 percent Full Compliance for Delivery System was also commendable.

Opportunities for Improvement and Recommendations

The standards associated with Grievance System and Reinsurance showed relatively high priority opportunities for improvement. The current review included 22 standards associated with Grievance System covering several aspects of grievance processing and reporting. Appropriate grievance systems can be an important source of information about areas of need for quality improvement activities, and appropriately structured and responsive grievance systems can markedly improve member satisfaction. Grievance systems are also important for transparency, which is fundamental to timely access to quality care, as well as to quality improvement.

Recommendation: The plan should consider initiating a comprehensive evaluation of its grievance system structure and processes that could include flow-charting both current and ideal processes to identify areas of performance vulnerability and opportunities to strengthen both performance and checks-and-balances systems of monitoring. Ideally, the evaluation would identify the factors that are contributing to the failure to fully comply with requirements (i.e., incomplete or unclear policies and procedures, staff performance such as failure to perform required actions within required time frames or failure to document the actions, and failure of the plan to conduct sufficiently detailed and frequent monitoring, etc.). The plan should also consider identifying opportunities to increasingly automate systems for logging and tracking information and actions related to the processing of grievances. For example, Technical Standard GS5 states: "The Health Plan provides the member written notice of the reason for the decision to extend the timeframe." This standard examined standing policy and the methods implemented for complying with the requirement. The standard was in Non-Compliance. This would be an excellent opportunity for the plan to automate logging and tracking of the timelines and required actions (i.e., sending a notice requesting an extension that includes the reason) and for auto-generating the notices with the reason for the extension built in as a required field, if these interventions are not already in place.

Reinsurance has been shown to be a statewide opportunity for improvement, and Mercy Care was not excluded from that finding, with only one of the standards scored as fully compliant. As previously shown, the State regulations appear sufficiently clear for the plan to successfully align its policies and procedures to ensure that processes are in place for properly handling reinsurance issues. The creation of fully compliant policies and procedures related to processing of encounter information, especially for reinsurance, involves a comparison of current information to the State's requirements.

Recommendation: The plan should consider appointing a time-limited work group to conduct a comprehensive and detailed review of the plan's reinsurance policies, procedures, and practices to ensure that its policies and procedures are consistent and fully compliant with the State's

requirement. The plan should also ensure that the policies and procedures provide clear and specific guidance to those responsible for implementing the policies and procedures.

Performance Measure Review

Strengths

The 10 performance measures that exceeded the minimum AHCCCS performance standards were a recognized strength for the health plan. The improvement in the number of measures exceeding the minimum AHCCCS performance standards (i.e., from 9 in the previous measurement period to 10) was commendable, as was the improvement in 2 of the 3 measures that continue to not meet the minimum AHCCCS performance standards.

Opportunities for Improvement and Recommendations

Three opportunities for improvement were presented for the following performance measures: Children's Access to PCPs, Breast Cancer Screening, and Cervical Cancer Screening. The rates for these measures were below the minimum AHCCCS performance standards. Yet, the rates for the three measures were not uniformly below the minimum standards. For example, the rate for Children's Access to PCPs was only one-fifth of a percentage point below the minimum AHCCCS performance standard, whereas the rate for Breast Cancer Screening was almost 10 percentage points below the minimum standard. The Cervical Cancer Screening rate was more than 3 percentage points below the minimum standard.

Recommendation: The plan should consider prioritizing its efforts to improve performance on measures that require the greatest improvement to ensure that all three measures meet or exceed the minimum level required before the next measurement cycle.

Because the health plan's performance on Children's Access to PCPs was only slightly under the minimum required rates, it seems reasonable to assume that the plan has identified specific interventions that have been effective in improving performance.

Recommendation: The health plan should consider enhancing the frequency of its monitoring of performance in this area to determine if the existing strategies continue to be effective in improving performance or if revised or additional strategies need to be implemented to ensure continued improvement on this measure.

Breast and Cervical Cancer Screening appeared to require more aggressive and potentially revised or additional interventions to ensure that performance meets or exceeds the minimum required levels.

Recommendation: Because obtaining these screenings may require women to make an additional appointment with a different provider in a different location, the health plan should consider evaluating the extent to which access to these appointments, in addition to routine appointments with the PCP, is a barrier to performance in this area. In addition to identifying other probable causes for the rates not meeting the minimum required and implementing targeted interventions, the plan should consider exploring opportunities and strategies to provide one or more of the required services during any type of office visit and consolidating radiology and the office visit as though

they were a single appointment. In addition, if not currently in place, automated notices to physicians identifying members due for the required screenings, and automated reminders and enhanced educational information sent to members, may positively impact the performance rates.

Review of PIPs

Strengths

Performance in conducting PIPs is an overall strength for the health plan. The rates improved for all three assessed measures. Further, the rates for both measures of adult diabetes management were considerably above average from a national perspective.

Opportunities for Improvement and Recommendations

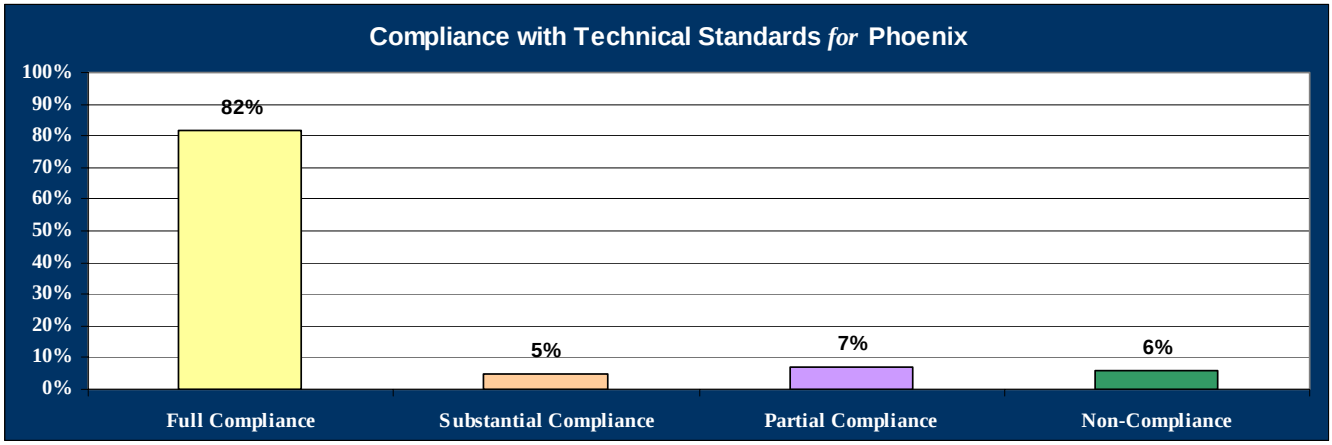
Opportunities for improvement exist wherever performance is not perfect. Nonetheless, these opportunities must be prioritized to make the best use of limited resources and to accomplish the most-needed improvements. For this reason, no specific opportunities for improvement or recommendations are offered for Mercy Care's PIPs.

Phoenix Health Plan (Phoenix)

Compliance with Standards (Operational and Financial Review)

Figure 3-18 shows Phoenix Health Plan's percentage of compliance with the technical standards reviewed in CY 2005–2006. The percentages of the standards in Full Compliance, Substantial Compliance, Partial Compliance, and Non-Compliance are shown separately.

Figure 3-18—Compliance with Technical Standards *for* Phoenix



When interpreting the information in Figure 3-18, the difference between at least Partial Compliance and Full Compliance reflects a scenario in which the health plan seems to know the intent of the technical standards but is not fully achieving compliance. This scenario contrasts with Non-Compliance, which indicates that the health plan might not understand the intent of the technical standards. In the first case (i.e., understanding but not fully achieving compliance with the technical standards), the health plan might make large strides in attaining Full Compliance with relatively little effort. Moving a technical standard from Non-Compliance to Full Compliance, however, might require technical assistance and other activities, such as those delineated in the section on opportunities for improvement and recommendations. The health plan's Non-Compliance rate of 6 percent was two-thirds the size of the statewide average of 9 percent. The health plan is commended for this result. Substantially and partially compliant standards were 5 percent and 7 percent, respectively, of the total number of standards across the nine reviewed categories.

Nonetheless, this overall pattern of results can obscure specific strengths and opportunities for improvement for specific categories of standards. Figure 3-19 shows the extent of compliance for each of the major areas within the technical standards. The figure highlights areas of strength and areas with more opportunities for improvement than in others. In each category, the figure shows the level of compliance with the technical standards based on Full Compliance, Substantial Compliance, Partial Compliance, and Non-Compliance.

Figure 3-19—Categorized Levels of Compliance with Technical Standards *for* Phoenix

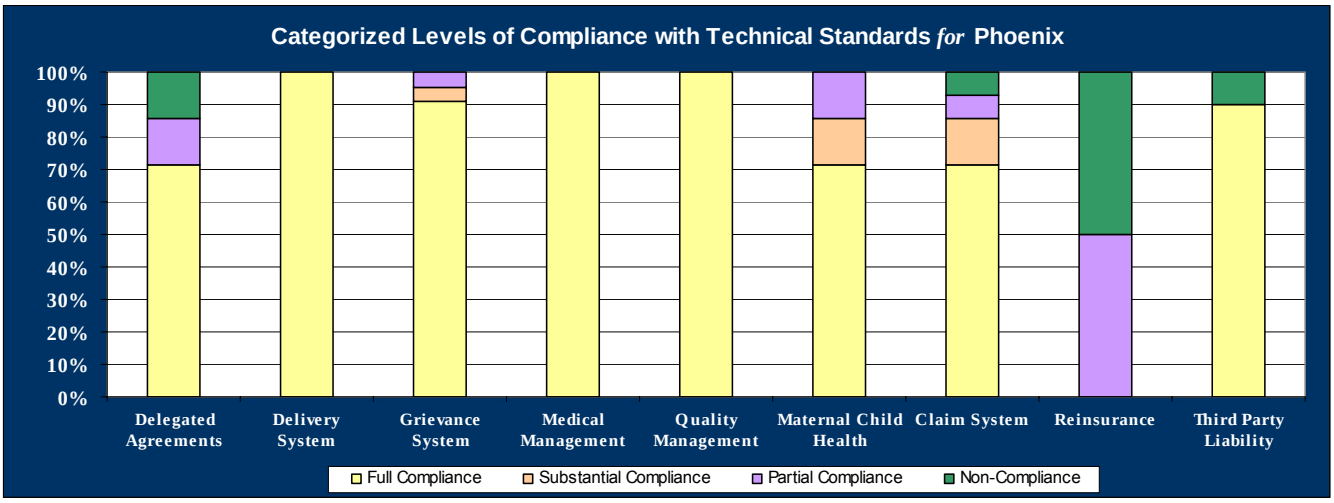


Figure 3-19 shows a very different pattern of results than was seen in Figure 3-18. The overall commendable results are evident in Figure 3-19 for Delivery System, Medical Management, and Quality Management, each of which received all fully compliant ratings for their associated standards. The results from the Grievance System category also compare well to the statewide results (shown earlier in Figure 3-2). Nonetheless, a significant and high-priority opportunity for improvement existed within the four standards for the Reinsurance category, followed by the standards within the Delegated Agreements category.

CAPs for Compliance with Standards

Table 3-14 shows each of the categories of technical standards reviewed, the number of CAPs required, the percentage of all CAPs in each category, the number of technical standards in each category, and the percentage of technical standards for each category with a required CAP.

Table 3-14—CAP Overview *for* Phoenix

Categories of Technical Standards	Number of CAPs	Percent of Total CAPs	Total Number of Standards	CAPs as a Percent of Standards
Delegated Agreements	2	11%	7	29%
Delivery System	0	0%	11	0%
Grievance System	2	11%	22	9%
Medical Management	0	0%	5	0%
Quality Management	1	6%	3	33%
Maternal and Child Health	4	22%	7	57%
Claims System	4	22%	14	29%
Reinsurance	4	22%	4	100%
Third Party Liability	1	6%	10	10%
Total	**18**	**100%**	**83**	**22%**

Table 3-14 shows that neither Delivery System nor Medical Management required a CAP in the current assessment cycle. The categories for Quality Management and Third Party Liability each required only one CAP. Conversely, Maternal and Child Health, Claims System, and Reinsurance each required four CAPs. These three categories accounted for two-thirds of the required CAPs, but included only 30 percent of the technical standards. Overall, 22 percent of the health plan's technical standards required a CAP.

Performance Measure Review

Table 3-15 shows the separate performance measures for the two most recent time periods, along with the statistical significance for each of the changes in rates over time. Additionally, the table presents the minimum AHCCCS performance standards and whether a CAP was required.

Table 3-15—Performance Measurement Program *for* Phoenix			
Performance Measure	Previous Measurement Period[1]	Actual Performance for Oct. 1, 2004, to Sept. 30, 2005	Minimum AHCCCS Performance Standard
Children's Access to PCPs[2]	75.4%	77.2%*	79%
Adult's Access to Preventive/Ambulatory Health Services[2]	77.8%	77.9%	80%
Breast Cancer Screening[2,3]	42.3%	46.9%*	57%
Cervical Cancer Screening[2,4]	32.9%	(27.4%)*	61%
Timeliness of Prenatal Care[4]	61.4%	(56.3%)	62%
Childhood Immunization—4 DTaP	**86.6%**	**(83.3%)**	83%
Childhood Immunization—3 IPV	**94.3%**	**(92.6%)**	89%
Childhood Immunization—1 MMR	**94.3%**	**(94.1%)**	90%
Childhood Immunization—3 HiB	**91.2%**	**(87.7%)**	76%
Childhood Immunization—3 HBV	**92.0%**	**(88.5%)**	82%
Childhood Immunization—1 VZV	**86.1%**	**(85.3%)**	77%
Childhood Immunization—DTP, IPV, & MMR (4:3:1 Series)	**85.8%**	**(81.1%)**	80%
Childhood Immunization—DTP, IPV, MMR, HIB, & HBV (4:3:1:3:3 Series)	**80.9%**	**(74.4%)***	70%

Notes:

Bolded rates exceed the minimum AHCCCS performance standard.

Nonbolded rates in the current measurement cycle require a CAP.

() Parentheses for current performance indicate a decrease from the previous measurement cycle.

* Statistically significant change from the previous measurement period at $p \leq .05$.

[1] Children's Access to PCPs and Adult's Access to Preventive/Ambulatory Health Services performance measures are measured and reported annually. All other performance measures are measured and reported on a rotating basis to allow health plans an intervention year between reporting periods.

[2] AHCCCS changed the methodology for collecting data and used a data warehouse to gather rate information. In order to have valid comparisons with data collected using the new process, AHCCCS used the data warehouse to recalculate rates for the previous year using the current methodology. Therefore, the rates in this report cannot be directly compared with the rates detailed in the 2006 EQRO report.

[3] The previous remeasurement period for Breast Cancer Screening was Oct. 1, 2002, through Sept. 30, 2004. The current measurement period is Oct. 1, 2003, through Sept. 30, 2005.

[4] The previous remeasurement period for Cervical Cancer Screening and Timeliness of Prenatal Care was Oct. 1, 2003, through Sept. 30, 2004.

The bolded rates show that the plan exceeded the minimum AHCCCS performance standards for eight measures, leaving five nonbolded rates that require CAPs. Ten of the 13 rates declined between measurement periods, but only Cervical Cancer Screening and Childhood Immunizations—DPT, IPV, MMR, HIB, & HBV (4:3:1:3:3 Series) declined by statistically significant amounts ($p \leq .05$). The rates for 8 of these 10 measures were above the minimum

AHCCCS performance standards. Cervical Cancer Screening and Timeliness of Prenatal Care were the two decreasing measures that were below the minimum AHCCCS performance standards in both measurement periods. The rates for Children's Access to PCPs and for Breast Cancer Screening improved by statistically significant amounts ($p \leq .05$).

Performance Measures—CAPs

Table 3-15 shows that 5 of the 13 performance measures (i.e., 38 percent) required a CAP by not reaching the minimum AHCCCS performance standards. Overall, the number of measures that exceeded the minimum AHCCCS performance standards remained constant at 8 of the 13 (i.e., 62 percent) reviewed performance measures in the current measurement cycle. The 5 measures requiring a CAP were: Children's Access to PCPs, Adult's Access to Preventive/Ambulatory Health Services, Breast Cancer Screening, Cervical Cancer Screening, and Timeliness of Prenatal Care.

Review of PIPs

Figure 3-20 presents the results of Phoenix's two PIPs, adult diabetes management and children's oral health. The figure shows improvement in each of the measures used to assess these PIPs.

Figure 3-20—PIP Results *for* Phoenix

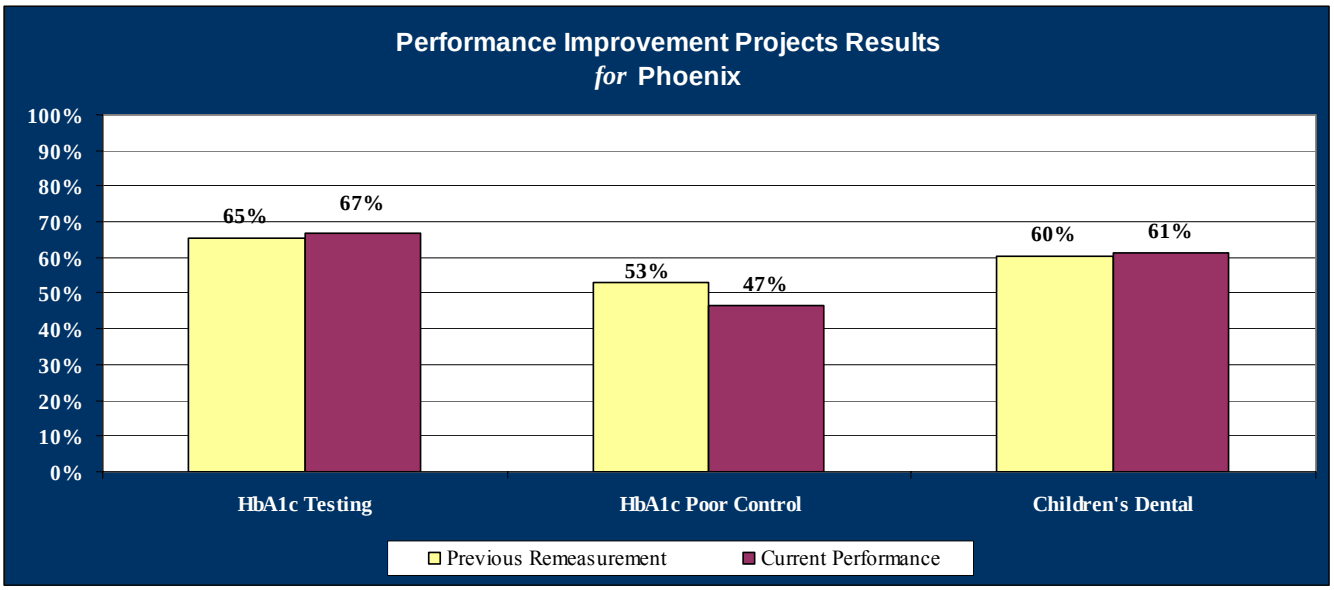


Figure 3-20 also suggests that the rates for the diabetes indicators were somewhat low from a national perspective. HbA1c testing was below the national 25th percentile HEDIS Medicaid rate of 69.8 percent. The HbA1c poor control measure, for which a decrease (as shown in the figure) indicates improvement, was equivalent to the HEDIS 50th percentile rate. The children's oral health measure improved from 60 percent to 61 percent.

Phoenix reported that certain process improvements, including ongoing reporting of lab and claims data to the quality committee, helped drive the development of new goals and interventions to improve diabetes management outcomes. Additionally, Phoenix reported having implemented a

stratification process by which diabetic members were assigned to varying risk groups. The process allowed Phoenix to develop interventions appropriate to the risk level of the individual. Phoenix also identified the lower 10 percent of providers for their percentage of HbA1c testing (<80 percent of adult diabetic members) and implemented a rapid cycle improvement project.

For the Children's Dental PIP, Phoenix reported numerous ongoing interventions to improve PIP outcomes. These interventions included: identifying children who had not been seen or were "no-shows"; contacting members who were "no-shows" to encourage dental visits; providing member education through newsletters, the plan Web site and other outreach materials; working with community resources to improve dental outreach; and working with the dental community to improve care to members. Phoenix reported that it will continue its member outreach program and work with the dental community to improve care to members.

Strengths, Opportunities for Improvement, and Recommendations for Phoenix

The next three sections discuss: (1) compliance with standards, (2) performance measures, and (3) PIPs. Each of these three sections presents the strengths found in the documentation provided to HSAG, opportunities for improvement, and recommendations.

Compliance with Standards (Operational and Financial Review)

Strengths

The compliance review showed Full Compliance with each of the standards associated with Delivery System, Medical Management, and Quality Management. These categories of technical standards were, therefore, considered strengths for the health plan. Performance of 90 percent Full Compliance within Grievance System and Third Party Liability standards was also commendable.

Opportunities for Improvement and Recommendations

The combined results from Figure 3-19 and Table 3-14 strongly suggest that Reinsurance should be the highest-priority opportunity for improvement. Delegated Agreements, Maternal and Child Health, and Claims System are additional areas for improvement.

Reflecting a statewide opportunity for improvement, Reinsurance standards were particularly troublesome for Phoenix. Of the four technical standards within the category, Phoenix was in Non-Compliance for two of the standards and in Partial Compliance for the remaining two standards. These scores were the second-lowest in the State for this category in the compliance review. As previously shown, the AHCCCS regulations appeared sufficiently clear for the plan to align its policies and procedures to ensure that the processes were in place for properly addressing reinsurance requirements. The creation of fully compliant policies and procedures related to processing of encounter information, especially for Reinsurance, involves a comparison of current information to the State's requirements.

Recommendation: The health plan should consider appointing a time-limited work group to conduct a comprehensive and detailed review and analysis of the plan's policies, procedures, and practices related to reinsurance and to revise them as applicable. The goals should be to ensure that the plan's

policies/procedures are: (1) consistent with and include all requirements as defined in the current State and federal requirements, and (2) detailed and clear in describing the procedures to be followed to ensure compliance with the requirements.

To improve performance on standards in the Delegated Agreements category, it appeared that some of the standards could be brought into compliance relatively easily. For example, DA4 was scored as Partially Compliant. The standard states "The contracts/written agreements for delegated functions contain the required Minimum Subcontract provisions, per AHCCCS requirements." The minimum subcontract provisions are available to all contractors to include in their contracts.

Recommendations: The plan should consider conducting a comprehensive and detailed review of its delegation agreements that includes comparing each template and executed agreement to the AHCCCS requirements. The plan should also consider conducting a similar process at each point in time that the AHCCCS contract or binding policies change related to the minimum required provisions that must be in the plan's delegation agreements. If not currently operational, the plan should consider an electronic logging/tracking system that would document that each delegation agreement includes all the AHCCCS requirements.

For Maternal and Child Health, five of the seven standards within the category involve compliance with EPSDT requirements. A sixth standard reviews the training and use of the PEDS tools, which has ramifications for physician practice, member health, and State monitoring of children's services. The only standard that is not directly related solely to children's health assesses the extent to which services are coordinated with other agencies according to State and federal requirements. These standards set minimum levels of care to ensure that some of the most potentially vulnerable plan members (i.e., children) have timely access to quality care. Furthermore, children are less likely than adults to complain about care, and adults are not always sufficiently versed in children's health care needs and guidelines to be the most appropriate advocates for their children.

Recommendation: The plan should consider conducting a detailed and comprehensive side-by-side comparison of its EPSDT policies and guidelines with the associated State and federal requirements to assess the degree of completeness and clarity of the plan's policies and guidelines. The plan should also revise the policies and guidelines to be consistent and fully compliant with State and federal requirements. In addition, the plan should consider appointing a staff person or designated quality body to ensure that the plan remains current in its knowledge of any changes to State and federal requirements and that the plan's documents are revised accordingly.

For the four technical standards with required CAPs in the Claims System category, one was in Non-Compliance, one was in Partial Compliance, and two were in Substantial Compliance. The standard in Non-Compliance was CS5.[3-5] The benchmarks for this standard appeared quite clear.

Recommendation: The health plan should consider as a first step ensuring that its policies and requirements related to Claims System are sufficiently detailed, clear, and consistent with State requirements so as to leave no room for misunderstanding of the expectations by those required to be in compliance with the requirements. Once comfortable that the plan's policies are sufficient, the

[3-5] CS5 states ""The Health Plan adjudicates 95% (90% for Health Plans with less than 50,000 members) of all clean claims within 30 days of receipt and 99% of clean claims within 60 days of receipt (unless otherwise specified in provider subcontract)."

health plan should consider conducting a root cause analysis to identify any other casual factors contributing to less than full compliance in order to target the interventions with the greatest likelihood of improving performance. The plan should consider whether or not it would be productive to initiate a system of incentives and/or withholds/sanctions related to performance on the standards, if not currently operational.

Performance Measure Review

Strengths

The strengths of Phoenix's performance measure review were offset by corresponding opportunities for improvement. For example, while 8 of the 13 performance measures exceeded the minimum AHCCCS performance standards, the statewide averages for 9 of the measures were above the minimum AHCCCS performance standards. In addition, all eight of the rates that were above the AHCCCS minimum standard declined between the two most recent measurement periods, one of them by a statistically significant amount ($p \leq .05$). The rates that did not reach the minimum AHCCCS performance standards showed similarly mixed results. Rates for three of the five measures increased—with two of the three increasing by a statistically significant amount (i.e., $p \leq .05$), and two rates decreased—with one of the two decreasing by a statistically significant amount.

Opportunities for Improvement and Recommendations

There were five performance measures with rates below the minimum AHCCCS performance standards. These measures were: Children's Access to PCPs, Adult's Access to Preventive Ambulatory Health Services, Breast Cancer Screening, Cervical Cancer Screening, and Timeliness of Prenatal Care. By having rates below the minimum AHCCCS performance standards and associated required CAPs, these measures were clear opportunities for improvement.

Children's Access to PCPs can be more difficult to improve than many other measures. One contributing factor may be that for appointments for children, the schedules of both the child and the person bringing the child to the PCP are involved, whereas appointments for adults typically involve just the schedule of the adult visiting the PCP on his or her own.

Recommendation: In addition to identifying probable causes for performance below the minimum required standard and implementing targeted interventions to improve performance, the plan should consider comparing the hours of provider availability and the hours of available public transportation with the times of the day and days of the week that working parents whose children are eligible for Medicaid services can typically bring their children to see a PCP. If indicated by the analysis, the plan should require increased provider availability in the evenings and on weekends. In addition, the plan should consider whether it has a sufficient provider and member reminder system in place and whether enhancing the system and/or enhancing the frequency and content of member informational materials have potential for improving performance.

The health plan might find that the changes needed to improve access for children could also be effective for improving the rate for Adult's Access to Preventive/Ambulatory Health Services. Members need to make and keep appointments for physicians to provide appropriate preventive/ambulatory care.

Recommendation: The health plan should consider implementing or enhancing physician and member reminder systems, enhancing member educational materials, and analyzing the sufficiency of the network in offering appointments for working adults in the evening and on weekends.

Breast and Cervical Cancer Screening might require very different interventions to improve rates because both of these services are rarely performed during a routine PCP office visit. For these screenings, women often must make additional appointments with a different provider and in a different location.

Recommendation: In addition to identifying other probable causes for the rates not meeting the minimum required and implementing targeted interventions, the plan should consider exploring opportunities and strategies to provide one or more of the required services during any type of office visit, and consolidating radiology and the office visit as though they were a single appointment. In addition, if not currently in place, automated notices to physicians identifying members due for the required screenings and automated reminders and educational information sent to members may positively impact the performance rates.

Improving the rate for Timeliness of Prenatal Care has challenges similar to those involved in improving access to PCP appointments and preventing health screenings.

Recommendations: The health plan should consider if its methods for and frequency of distributing targeted member informational materials and reminder notices about scheduled appointments could be enhanced. In addition, the health plan may want to assess the extent to which evening and week-end appointments are available to working pregnant woman who may find it difficult to schedule appointments during regular business/clinic hours.

Recommendation: In addition to the above recommendations, the plan should consider conducting a comprehensive provider and member profiling project. For providers, the project would focus on identifying patterns of less-than-acceptable performance by individual providers and provider group practices related to each of the performance measures. For members, the project would focus on any clear patterns of member characteristics for those not receiving the appropriate screenings and immunizations, compared with those who are. Specific and targeted interventions could then focus on providers with the poorest performance and members who are not participating in their own preventative health care.

Review of PIPs

Strengths

Performance for the Children's Dental PIP was a clear strength with rates for the previous and the current year of 60 percent and 61 percent respectively. Although both diabetes management indicators showed improvement, the actual rates showed opportunities for continued improvement when compared with national HEDIS Medicaid percentile rates.

Opportunities for Improvement and Recommendations

The plan appeared to clearly understand the challenges of continuous improvement and implemented a pilot study to assess the effect of allowing providers to conduct HbA1c testing in

their offices rather than sending members to labs for testing. The results of the study and implementation remain to be seen. The concept, however, seems to be an excellent strategy to overcome an often-cited barrier to access for this type of testing. No additional opportunities for improvement or recommendations are offered for Phoenix's PIPs.

Pima Health System (Pima)

Compliance with Standards (Operational and Financial Review)

Figure 3-21 shows Pima's percentage of compliance with the technical standards selected for review in CY 2005–2006. The percentages of the standards in Full Compliance, Substantial Compliance, Partial Compliance, and Non-Compliance are shown separately.

Figure 3-21—Compliance with Technical Standards *for* Pima

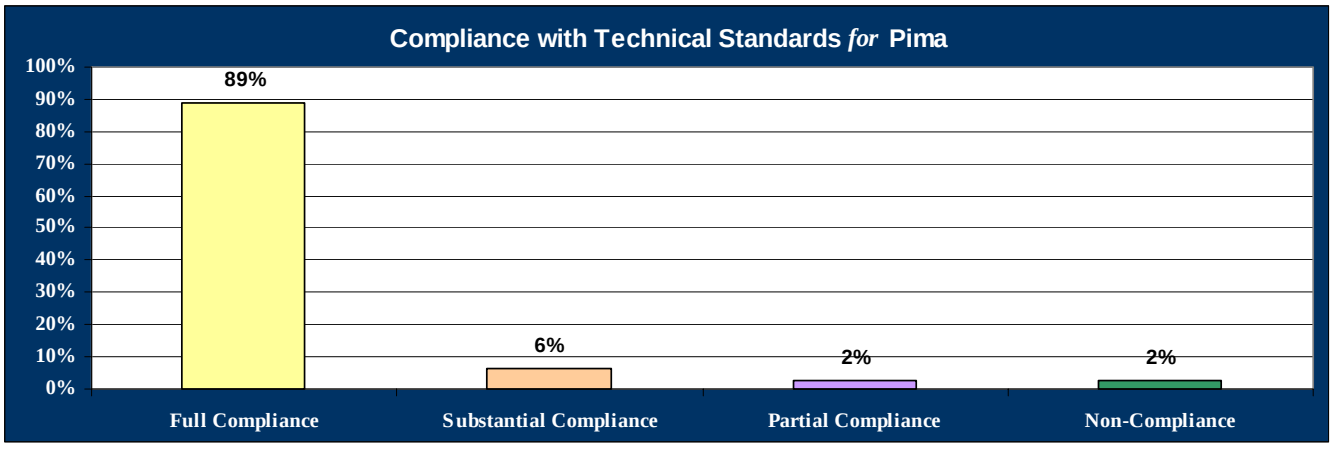


Figure 3-21 presents the best overall individual plan results in the State for the review of compliance with technical standards, with 89 percent of all standards in Full Compliance and only 2 percent in Non-Compliance. When interpreting the information in Figure 3-21, the difference between at least Partial Compliance and Full Compliance reflects a scenario in which the health plan seems to know the intent of the technical standards but is not fully achieving compliance. This scenario contrasts with Non-Compliance, which indicates that the health plan might not understand the intent of the technical standards. In the first case (i.e., understanding but not fully achieving compliance with the technical standards), the health plan might make large strides in attaining Full Compliance with relatively little effort. Moving a technical standard from Non-Compliance to Full Compliance, however, might require technical assistance and other activities, such as those delineated in the section on opportunities for improvement and recommendations. The health plan's rate of Non-Compliance of 2 percent was less than one-quarter the size of the statewide average of 9 percent. The health plan is commended for this result. Substantially and partially compliant standards were 6 percent and 2 percent, respectively, of the total number of standards across the nine categories reviewed.

Notwithstanding, this overall pattern of performance results can obscure opportunities for improvement for specific categories of standards. Figure 3-22 shows the extent of compliance for each of the major areas within the technical standards. The figure highlights areas of strength and areas with opportunities for improvement. In each category, the figure shows the level of compliance with the technical standards based on Full Compliance, Substantial Compliance, Partial Compliance, and Non-Compliance.

Figure 3-22—Categorized Levels of Compliance with Technical Standards *for* Pima

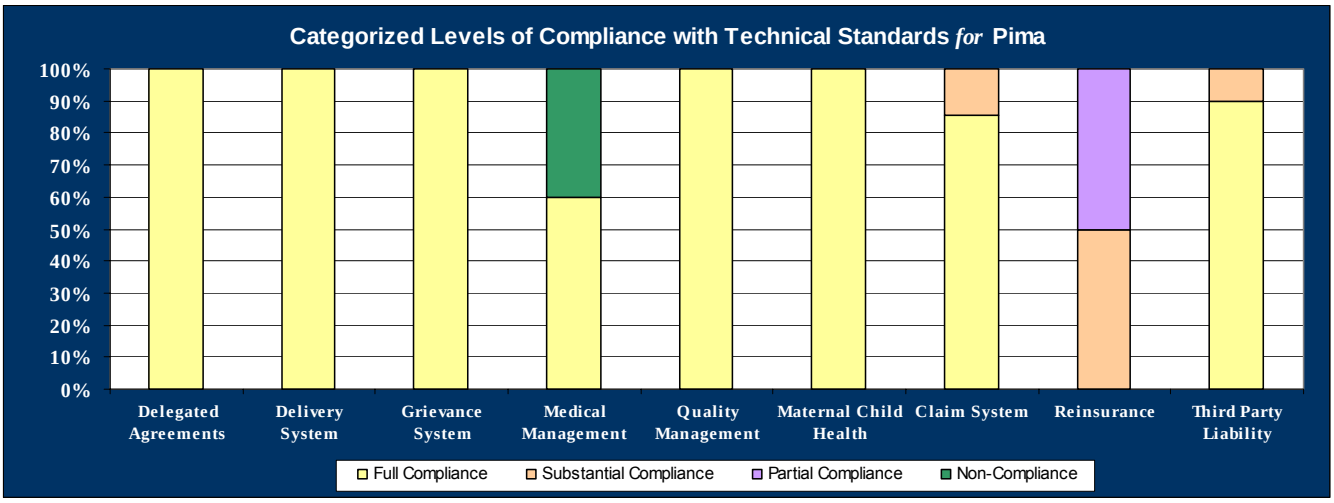


Figure 3-22 shows that the Delegated Agreements, Delivery System, Grievance System, Quality Management, and Maternal and Child Health categories were scored in Full Compliance with requirements for all of the technical standards. Claims System and Third Party Liability were close to Full Compliance with only two standards in Claims System and one in Third Party Liability in Substantial Compliance. While there were clear opportunities for improvement, primarily in the categories of Medical Management and Reinsurance, overall, the exceptional performance seen in Figure 3-21 was also seen in Figure 3-22.

CAPs for Compliance with Standards

Table 3-16 presents each of the categories of technical standards reviewed, the number of CAPs required, the percentage of all CAPs in each category, the number of technical standards in each category, and the percentage of technical standards for each category with a required CAP.

Table 3-16—CAP Overview *for* Pima

Categories of Technical Standards	Number of CAPs	Percent of Total CAPs	Total Number of Standards	CAPs as a Percent of Standards
Delegated Agreements	0	0%	6	0%
Delivery System	0	0%	11	0%
Grievance System	0	0%	22	0%
Medical Management	2	25%	5	40%
Quality Management	0	0%	3	0%
Maternal and Child Health	0	0%	7	0%
Claims System	1	13%	14	7%
Reinsurance	4	50%	4	100%
Third Party Liability	1	13%	10	10%
Total	**8**	**100%**	**82**	**10%**

Table 3-16 supports the findings from Figure 3-22 by suggesting exceptional overall compliance with the technical standards, and that Medical Management and Reinsurance should be prioritized when addressing opportunities for improvement. In addition, the health plan's rate for technical standards requiring a CAP, at 10 percent, was slightly more than half the 18 percent rate of the next-highest performing health plan, and compared very favorably with the 26 percent statewide rate.

Performance Measure Review

Table 3-17 shows the separate performance measures for the two most recent time periods, along with the statistical significance for each of the changes in rates over time. Additionally, the table presents the minimum AHCCCS performance standards and whether a CAP was required.

Table 3-17—Performance Measurement Program *for* Pima			
Performance Measure	Previous Measurement Period[1]	Actual Performance for Oct. 1, 2004, to Sept. 30, 2005	Minimum AHCCCS Performance Standard
Children's Access to PCPs[2]	**80.4%**	**81.7%**	79%
Adult's Access to Preventive/Ambulatory Health Services[2]	77.2%	78.2%	80%
Breast Cancer Screening[2,3]	**57.3%**	(54.6%)	57%
Cervical Cancer Screening[2,4]	49.4%	57.3%*	61%
Timeliness of Prenatal Care[4]	**62.8%**	(59.3%)	62%
Childhood Immunization—4 DTaP	**88.8%**	**94.4%**	83%
Childhood Immunization—3 IPV	**92.8%**	**98.3%***	89%
Childhood Immunization—1 MMR	**94.4%**	**97.8%**	90%
Childhood Immunization—3 HiB	**92.8%**	**96.1%**	76%
Childhood Immunization—3 HBV	**90.4%**	**93.1%**	82%
Childhood Immunization—1 VZV	**91.2%**	**95.7%**	77%
Childhood Immunization—DTP, IPV, & MMR (4:3:1 Series)	**85.6%**	**92.6%***	80%
Childhood Immunization—DTP, IPV, MMR, HIB, & HBV (4:3:1:3:3 Series)	**76.8%**	**84.4%**	70%

Notes:

Bolded rates exceed the minimum AHCCCS performance standard.

Nonbolded rates in the current measurement cycle require a CAP.

() Parentheses for current performance indicate a decrease from the previous measurement cycle.

* Statistically significant change from the previous measurement period at $p \leq .05$.

[1] Children's Access to PCPs and Adult's Access to Preventive/Ambulatory Health Services performance measures are measured and reported annually. All other performance measures are measured and reported on a rotating basis to allow health plans an intervention year between reporting periods.

[2] AHCCCS changed the methodology for collecting data and used a data warehouse to gather rate information. In order to have valid comparisons with data collected using the new process, AHCCCS used the data warehouse to recalculate rates for the previous year using the current methodology. Therefore, the rates in this report cannot be directly compared with the rates detailed in the 2006 EQRO report.

[3] The previous remeasurement period for Breast Cancer Screening was Oct. 1, 2002, through Sept. 30, 2004. The current measurement period is Oct. 1, 2003, through Sept. 30, 2005.

[4] The previous remeasurement period for Cervical Cancer Screening and Timeliness of Prenatal Care was Oct. 1, 2003, through Sept. 30, 2004.

The bolded rates show that the plan exceeded the minimum AHCCCS performance standards for nine measures, leaving four nonbolded rates that require CAPs. While all but two of the rates improved between measurement periods, only three of the rates improved by a statistically significant amount ($p \leq .05$). The two declining rates had exceeded the minimum AHCCCS performance standard during the previous measurement period, but fell below the minimum

standard in the most recent measurement period. The amount of decline in each of the rates was not large enough to reach statistical significance ($p \leq .05$).

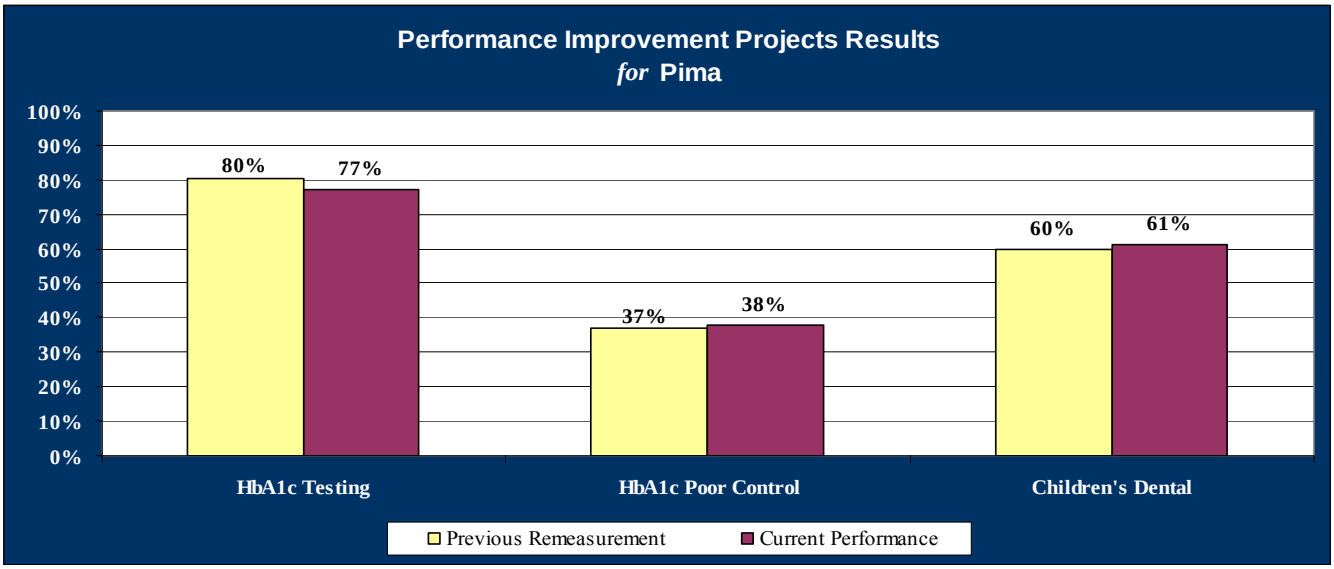
Performance Measures—CAPs

Table 3-17 shows that 4 of the 13 performance measures (i.e., 31 percent) required a CAP by not reaching the minimum AHCCCS performance standards. Overall, the number of measures that exceeded the minimum AHCCCS performance standards declined from 11 of the 13 (i.e., 85 percent) to 9 of the 13 (i.e., 69 percent) in the current measurement cycle. The four measures requiring a CAP were: Adult's Access to Preventive/Ambulatory Health Services, Breast Cancer Screening, Cervical Cancer Screening, and Timeliness of Prenatal Care.

Review of PIPs

Pima was the only health plan to show declining results for both adult diabetes management indicators. The final results show the plan to be just below the national HEDIS median percentile rate of 78.4 percent for HbA1c testing and exactly at the 25th national HEDIS percentile rate for HbA1c poor control. The Children's Dental rate increased from 60 percent to 61 percent.

Figure 3-23—PIP Results *for* Pima



Pima reported that it is committed to continuing the following interventions to regain and sustain improvement for adult diabetes management: including informational articles in provider and member newsletters; sending a special mailing to members in November of each year; sending written notification to primary care physicians from the Pharmacy Division related to members who did not comply with their diabetic medication refills as reflected by the available pharmacy utilization data; referring members to diabetic education programs; annually tracking and monitoring of HbA1c lab tests through the Information Systems (IS) Division; and reporting the amount and percentages of HbA1c lab tests at the quarterly Quality Management/Performance Improvement Committee meetings.

For Children's Dental, Pima reported numerous ongoing interventions to improve PIP outcomes. These interventions included: distributing member materials and informational packets describing the dental benefit, how to access services, and the benefits of dental care; contacting every member for whom a dental concern was documented on the provider-submitted EPSDT tracking form, providing information about the noted problem and offering assistance with making an appointment; personally notifying members of dental exams coming due according to a prescribed timeline; and requiring EPSDT providers to refer and encourage parents/guardians of members 3 to 21 years of age to go to the dentist as part of each EPSDT visit. EPSDT providers were informed of the Pima dental program through contract language, the provider manual, provider training sessions, communication and technical assistance provided by Pima staff, periodic site visits, and quarterly newsletters.

Strengths, Opportunities for Improvement, and Recommendations for Pima

The next three sections discuss: (1) compliance with standards, (2) performance measures, and (3) PIPs. Each of these three sections presents the strengths found in the documentation provided to HSAG, opportunities for improvement, and recommendations.

Compliance with Standards (Operational and Financial Review)

Strengths

With performance of 100 percent Full Compliance for five of nine categories of standards and close to fully compliant performance on an additional two categories, performance for the review of compliance with standards was an overall strength for Pima. With slightly more than half the focused and prioritized attention to areas that require continued improvement, the plan should be able to demonstrate Full Compliance with these standards for the next review cycle.

Opportunities for Improvement and Recommendations

The standards for Medical Management and Reinsurance, for which the plan was not fully compliant, were two opportunities for improvement that should be readily resolved, as should the one required CAP each for Claims System and for Third Party Liability. For Medical Management, the two standards with required CAPs involved utilization management. One of the standards examines the consistency of the plan's implemented procedures for utilization management program requirements with AHCCCS standards.

Recommendation: The plan should consider conducting a rigorous and detailed comparison of the relevant AHCCCS standards with the current plan standards to identify missing requirements or information that is not consistent with the AHCCCS standards and, as indicated through the review/comparison, revise the plan's policies and procedures.

The second standard involves the analysis of the plan's encounter/claims data for use in strategic planning and other utilization management purposes.[3-6] This standard assesses the plan's ongoing quality improvement process and the policies and procedures that support it.

Recommendation: The health plan should consider conducting a rigorous review of its internal policies and processes for analyzing encounter/claims data and for using the results of the analysis for strategic planning and all aspects of its utilization management and quality programs. A rigorous review should identify any inconsistencies between policies and actual practices, as well as gaps in the analysis of key data and information that is available. The review could inform the plan about its utilization management program performance and identify additional opportunities to strengthen utilization management processes and plan performance.

Performance Measure Review

Strengths

The strengths of Pima's performance measure review were somewhat offset by opportunities for improvement. For example, rates for 9 of the 13 performance measures exceeded the minimum AHCCCS performance standards; yet, rates for 11 of the 13 performance measures exceeded the standards in the previous measurement period and the improvement was not always continuing or statistically significant ($p \leq .05$). In addition, although 11 of the rates increased, the 2 decreasing measures did not exceed the minimum AHCCCS performance standards in the most recent measurement cycle even though both had reached it in the previous measurement cycle. The Childhood Immunization rates, however, were exceptionally high and continued to improve.

Opportunities for Improvement and Recommendations

There were four performance measures with rates below the minimum AHCCCS performance standards. These measures were: Adult's Access to Preventive/Ambulatory Health Services, Breast Cancer Screening, Cervical Cancer Screening, and Timeliness of Prenatal Care. By having rates below the minimum AHCCCS performance standards and an associated CAP, these measures were clear opportunities for improvement.

Improving the results for Adult's Access to Preventive/Ambulatory Health Services often involves improvement in four areas: accessibility of appointments, reminder systems for physicians, reminder systems for members, and education of members. Accessibility of appointments for working adults often involves the availability of evening and weekend provider hours that are geographically accessible to working adults.

Recommendation: The plan should consider conducting an analysis of the availability and sufficiency of provider evening and weekend hours that are geographically accessible to members and determine if there are opportunities to strengthen the plan's processes for physician and member reminders, and to enhance the processes for providing member education.

[3-6] "The Health Plan reviews utilization data and reports trends, variances, analysis/evaluation, interventions through the Medical Management Committee. The Health Plan acts and follows through on committee recommendations."

Breast and Cervical Cancer Screening might require very different interventions to improve rates. For these screenings, women often must make additional appointments with a provider other than their PCP, and in a different location.

Recommendation: In addition to identifying other probable causes for the rates not meeting the minimum required and implementing targeted interventions, the plan should consider exploring opportunities and strategies to provide one or more of the required services during any type of office visit, and consolidating radiology and the office visit as though they were a single appointment. In addition, if not currently in place, automated notices to physicians identifying members due for the required screenings and automated reminders and educational information sent to members may positively impact the performance rates.

Access, which is central to Adult's Access to Preventive/Ambulatory Health Services, is often an issue with Timeliness of Prenatal Care, as well.

Recommendation: The health plan should consider strategies similar to those described in the recommendation for Adult's Access to Preventive/Ambulatory Health Services.

Recommendation: In addition to the above recommendations, the plan should consider conducting a comprehensive provider and member profiling project. For providers, the project would focus on identifying patterns of less-than-acceptable performance by individual providers and provider group practices related to each of the performance measures. For members, the project would focus on any clear patterns of member characteristics for those not receiving the appropriate screenings and immunizations, compared with those who are. Specific and targeted interventions could then focus on providers with the poorest performance and members who are not participating in their own preventative health care.

Review of PIPs

Strengths

Performance rates increased by one percentage points from those attained for the previous measurement cycle for both the HbA1c Poor Control and Children's Dental measures. The documentation on the ongoing efforts to improve the plan's adult diabetes management indicator rates show the plan's commitment to quality improvement activities in this area

Opportunities for Improvement and Recommendations

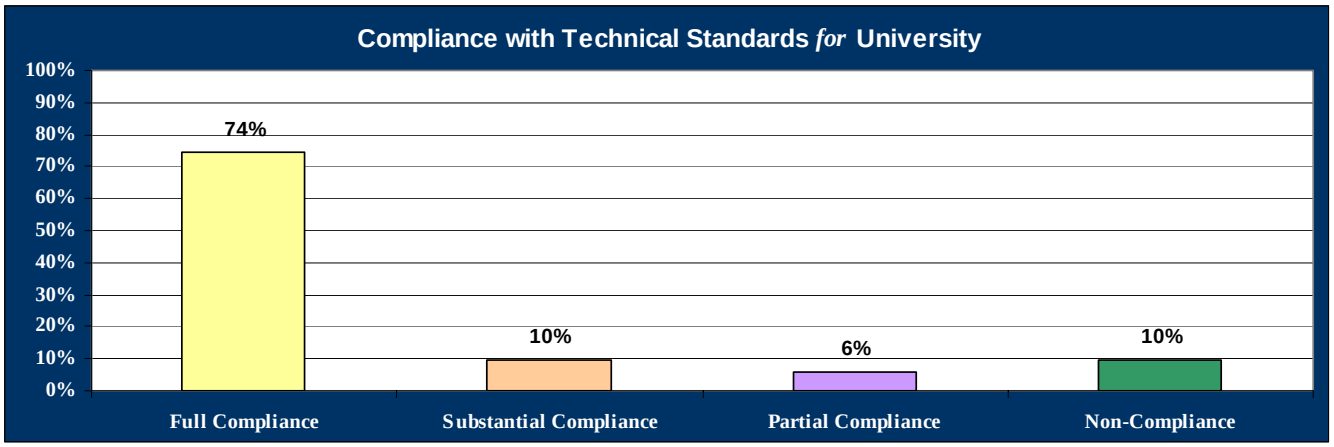
The previously reported activities that continue at the plan represent an appropriate level of focused and strategic effort to improve the adult diabetes management indicator rates, especially by combining testing and office visits. Therefore, there are no specific recommendations offered for Pima's PIPs.

University Family Care (University)

Compliance with Standards (Operational and Financial Review)

Figure 3-24 shows University's percentage of compliance with the technical standards selected for review in CY 2005–2006. The percentages of the standards in Full Compliance, Substantial Compliance, Partial Compliance, and Non-Compliance are shown separately.

Figure 3-24—Compliance with Technical Standards *for* University



When interpreting the information in Figure 3-24, the difference between at least Partial Compliance and Full Compliance reflects a scenario in which the health plan seems to know the intent of the technical standards but is not fully achieving compliance. This scenario contrasts with Non-Compliance, which indicates that the health plan might not understand the intent of the technical standards. In the first case (i.e., understanding but not fully achieving compliance with the technical standards), the health plan might make large strides in attaining Full Compliance with relatively little effort. Moving a technical standard from Non-Compliance to Full Compliance, however, might require technical assistance and other activities, such as those delineated in the section on opportunities for improvement and recommendations. The health plan's rate of Non-Compliance of 10 percent was just above the statewide average of 9 percent. In fact, each of the rates shown in Figure 3-24 was within 1 percentage point of the statewide average, suggesting overall average performance by the plan compared with the performance of all plans.

Figure 3-25 shows the extent of compliance for each of the major areas within the technical standards. The figure highlights both areas of strength and opportunities for improvement. In each category, the figure shows the level of compliance with the technical standards based on Full Compliance, Substantial Compliance, Partial Compliance, and Non-Compliance.

Figure 3-25—Categorized Levels of Compliance with Technical Standards *for* University

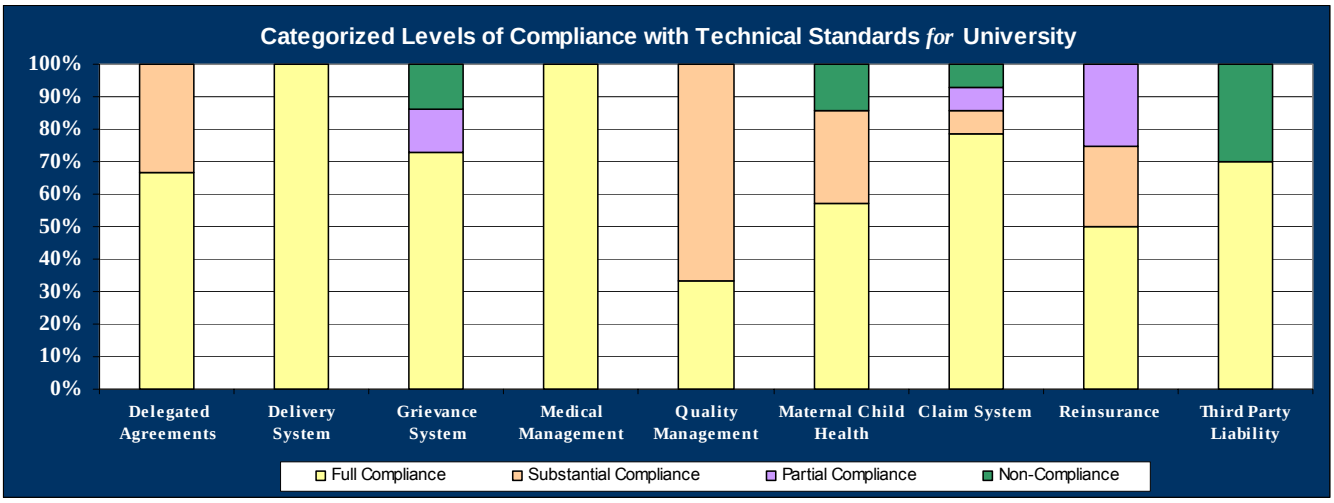


Figure 3-25 shows Full Compliance with all of the technical standards associated with Delivery System and with Medical Management, which were recognized strengths for the health plan. As presented in Table 3-18, opportunities for improvement were fairly evenly distributed across the other standards.

CAPs for Compliance with Standards

Table 3-18 presents each category of technical standards reviewed, the number of CAPs required, the percentage of all CAPs in each category, the number of technical standards in each category, and the percentage of technical standards for each category with a required CAP.

Table 3-18—CAP Overview *for* University

Categories of Technical Standards	Number of CAPs	Percent of Total CAPs	Total Number of Standards	CAPs as a Percent of Standards
Delegated Agreements	2	8%	6	33%
Delivery System	0	0%	11	0%
Grievance System	7	29%	22	32%
Medical Management	0	0%	5	0%
Quality Management	2	8%	3	67%
Maternal and Child Health	3	13%	7	43%
Claims System	5	21%	14	36%
Reinsurance	2	8%	4	50%
Third Party Liability	3	13%	10	30%
Total	**24**	**100%**	**82**	**29%**

Except for Delivery System and Medical Management, which did not have a required CAP, each of the other categories required between two and seven CAPs, representing 30 to 67 percent of the technical standards within each category. This pattern of required CAPs was more evenly spread across the categories than was generally seen in other health plans' results from the current review, suggesting that there may be some common factors affecting compliance for the standards with required CAPS. Overall, 29 percent of the technical standards required a CAP.

Performance Measure Review

Table 3-19 shows the separate performance measures for the two most recent time periods, along with the statistical significance for each of the changes in rates over time. Additionally, the table presents the minimum AHCCCS performance standards and whether a CAP was required.

Table 3-19—Performance Measurement Program *for* University			
Performance Measure	Previous Measurement Period[1]	Actual Performance for Oct. 1, 2004, to Sept. 30, 2005	Minimum AHCCCS Performance Standard
Children's Access to PCPs[2]	**81.0%**	**81.2%**	79%
Adult's Access to Preventive/Ambulatory Health Services[2]	**80.4%**	**(80.1%)**	80%
Breast Cancer Screening[2,3]	**57.0%**	(51.7%)	57%
Cervical Cancer Screening[2,4]	59.7%	(59.1%)	61%
Timeliness of Prenatal Care[4]	**63.4%**	**68.3%**	62%
Childhood Immunization—4 DTaP	78.8%	**87.4%***	83%
Childhood Immunization—3 IPV	**90.5%**	**94.9%**	89%
Childhood Immunization—1 MMR	**95.0%**	**96.0%**	90%
Childhood Immunization—3 HiB	**86.0%**	**89.1%**	76%
Childhood Immunization—3 HBV	**90.5%**	**92.6%**	82%
Childhood Immunization—1 VZV	**86.6%**	**86.9%**	77%
Childhood Immunization—DTP, IPV, & MMR (4:3:1 Series)	77.1%	**85.1%***	80%
Childhood Immunization—DTP, IPV, MMR, HIB, & HBV (4:3:1:3:3 Series)	69.8%	**76.6%**	70%

Notes:

Bolded rates exceed the minimum AHCCCS performance standard.

Nonbolded rates in the current measurement cycle require a CAP.

() Parentheses for current performance indicate a decrease from the previous measurement cycle.

* Statistically significant change from the previous measurement period at $p \leq .05$.

[1] Children's Access to PCPs and Adult's Access to Preventive/Ambulatory Health Services performance measures are measured and reported annually. All other performance measures are measured and reported on a rotating basis to allow health plans an intervention year between reporting periods.

[2] AHCCCS changed the methodology for collecting data and used a data warehouse to gather rate information. In order to have valid comparisons with data collected using the new process, AHCCCS used the data warehouse to recalculate rates for the previous year using the current methodology. Therefore, the rates in this report cannot be directly compared with the rates detailed in the 2006 EQRO report.

[3] The previous remeasurement period for Breast Cancer Screening was Oct. 1, 2002, through Sept. 30, 2004. The current measurement period is Oct. 1, 2003, through Sept. 30, 2005.

[4] The previous remeasurement period for Cervical Cancer Screening and Timeliness of Prenatal Care was Oct. 1, 2003, through Sept. 30, 2004.

The bolded rates show that the plan exceeded the minimum AHCCCS performance standards for 11 measures, leaving just 2 nonbolded rates that require CAPs. All but three of the rates improved between measurement periods, but only two rates improved by a statistically significant ($p \leq .05$) amount (i.e., Childhood Immunization—DTaP and Childhood Immunizations—DPT, IPV, & MMR (4:3:1, Series). Two of the decreasing rates that had exceeded the minimum AHCCCS performance

standard during the previous measurement period no longer did so. The third measure (i.e., Adult's Access to Preventative/Ambulatory Health Services), while decreasing in an amount that was not statistically significant continued to exceed the standard in the most recent measurement period. Lastly, the rates for two performance measures changed by a statistically significant amount ($p \leq .05$) between the two measurement cycles, bringing both of the measures from below the minimum AHCCCS performance standards to above them.

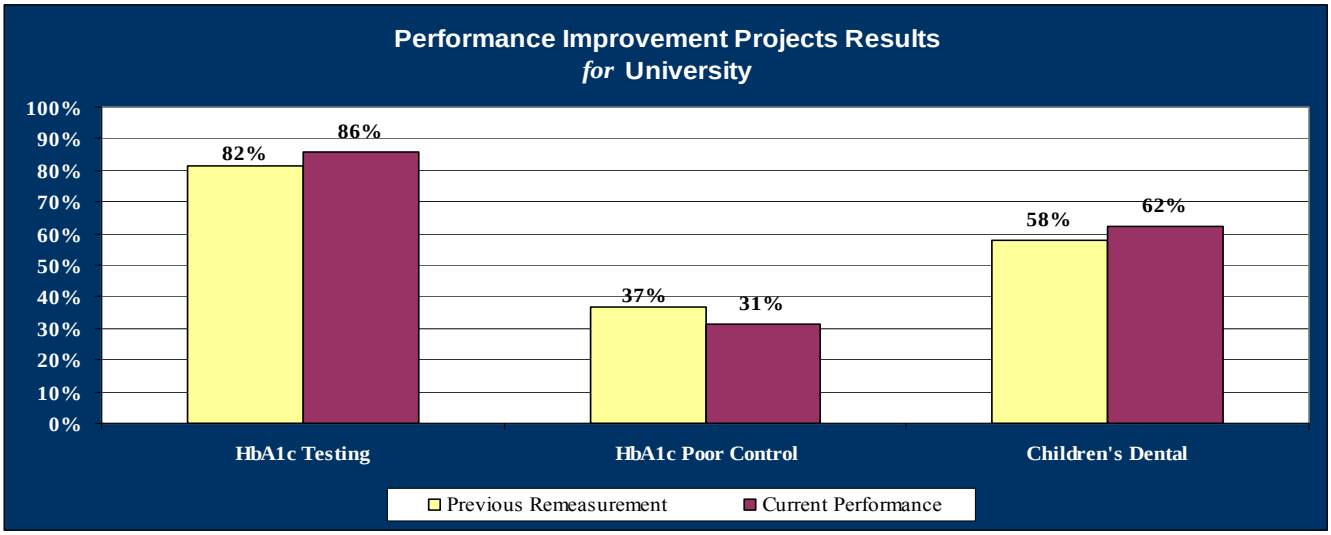
Performance Measures—CAPs

Table 3-19 shows that only 2 of the 13 performance measures (i.e., 15 percent) required a CAP by not reaching the minimum AHCCCS performance standards. This was the best performance among the plans statewide. Overall, the number of measures that exceeded the minimum AHCCCS performance standards increased from 9 of the 13 (i.e., 69 percent) to 11 of 13 (i.e., 85 percent) in the current measurement cycle. The two measures requiring a CAP were Breast and Cervical Cancer Screening, both of which also had required CAPs for all other plans statewide where the measures were applicable.[3-7]

Review of PIPs

Figure 3-26 presents the results of University's two PIPs, adult diabetes management and children's oral health. The figure shows improvement in each of the measures used to assess these PIPs. In addition, the rates for the diabetes indicators were strong from a national perspective. HbA1c testing was above the national 75th percentile HEDIS Medicaid rate of 84.1 percent. The HbA1c control measure, for which a decrease (as shown in the figure) indicates improvement, approximated the HEDIS 90th percentile rate after adjusting for the reversed structure of the measure. The children's oral health measure improved from 58 percent to 62 percent.

Figure 3-26—PIP Review Results *for* University



[3-7] See Table 4-2.

University reported success in overcoming several key barriers that impacted its diabetes management rates. These barriers included: members' lack of knowledge regarding diabetes, its complications, and proper nutrition in managing the disease; providers' lack of familiarity with diabetes management guidelines; and providers' lack of familiarity with member benefits for diabetes management. University reported that its interventions to improve outcomes stemmed from enhanced education. Specifically, University reported that it plans to continue using self-reporting questionnaires, provider and member newsletters, and follow-up phone calls to members who did not have an HbA1c test or whose test results showed HbA1c > 9.5.

University also reported numerous ongoing interventions to improve PIP outcomes related to Children's Dental. These interventions included: providing dentists with lists of members who had not had a comprehensive dental visit so they could contact the member and schedule an appointment, sending additional postcard reminders to families with children between 3 and 6 years of age, and generating an internal quarterly report that monitored dental rates to determine the extent to which interventions were successful.

Strengths, Opportunities for Improvement, and Recommendations for University

The next three sections discuss: (1) compliance with standards, (2) performance measures, and (3) PIPs. Each of these three sections presents the strengths found in the documentation provided to HSAG, opportunities for improvement, and recommendations.

Compliance with Standards (Operational and Financial Review)

Strengths

The health plan was in Full Compliance with all of the technical standards associated with Delivery System and Medical Management, making these areas of recognized strengths. Overall, however, the plan had slightly more difficulty complying with the standards reviewed as compared with the average statewide health plan performance. The plan had 29 percent of its standards requiring a CAP compared with 26 percent statewide.

Opportunities for Improvement and Recommendations

Opportunities for improvement were quite generalized for the plan, as shown in Table 3-18. The approach to this situation is somewhat different than it would be to improve performance for a single category of standards. With performance on the standards for seven of nine categories needing improvement, quality improvement requires finding root causes underlying the failure to achieve sufficiently high compliance across almost all of the compliance categories under review. While it is important to focus improvement activities on individual standards for which the health plan's performance was not fully compliant, it is also important for the plan to undertake a comprehensive review of its systems and operations to detect common and consistent barriers to performance that compromise the plan's performance across multiple categories of standards.

Recommendation: The health plan should consider either: (1) appointing a cross-departmental project team that is empowered to conduct a rigorous and comprehensive systems review and analysis designed to identify probable root causes that contributed to the lack of full compliance

with the requirements for seven of the nine categories and to make recommendations based on those findings, or (2) engage external resources skilled in facilitating a comprehensive systems analysis to provide the leadership and to work with staff members in conducting this kind of review. The systems review should be broad and inclusive of: (1) organizational structure and reporting (2) written policies and procedures (e.g., complete and detailed, clear and consistent with current AHCCCS and other binding requirements, etc.); (3) operational practices (e.g., adherence to policies and procedures, clear accountabilities for each process, etc.), (4) tightness of linkages/interface/hand-offs between and among related or interdependent systems and processes; (5) internal and external—provider/vendors/delegates—performance monitoring (e.g., targeted and specific, frequency, quality/sufficiency of processes and tools); (6) infrastructure to support required operations—(e.g., staffing, information systems/technology, communications; etc.); and other areas as identified by the plan as important to a complete and comprehensive review of the plan's systems and operations.

Performance Measure Review

Strengths

With performance for 11 of 13 measures exceeding the minimum AHCCCS performance standards, this area was a significant strength for the health plan. Improvement was shown in the increased number of measures (i.e., from 9 to 11) meeting or exceeding the minimum AHCCCS performance standards between the two most recent measurement periods.

Opportunities for Improvement and Recommendations

Because Breast and Cervical Cancer Screening rates declined and were below the minimum AHCCCS performance standards, they were high-priority opportunities for improvement. Breast and Cervical Cancer Screening might require overlapping interventions to improve the rates. For these screenings, women often must make additional appointments with a provider other than their PCP, and in a different location.

Recommendation: In addition to identifying other probable causes for the rates not meeting the minimum required and implementing targeted interventions, the plan should consider exploring opportunities and strategies to provide one or more of the required services during any type of office visit, and consolidating radiology and the office visit as though they were a single appointment. In addition, if not currently in place, automated notices to physicians identifying members due for the required screenings and automated reminders and educational information sent to members may positively impact the performance rates.

Review of PIPs

Strengths

The conduct of PIPs was an overall strength for the health plan. The rates improved for all three assessed measures. Further, the rates for both measures of adult diabetes management were considerably above average from a national perspective. In addition, the rate for the children's dental health measure improved by 4 percentage points.

Opportunities for Improvement and Recommendations

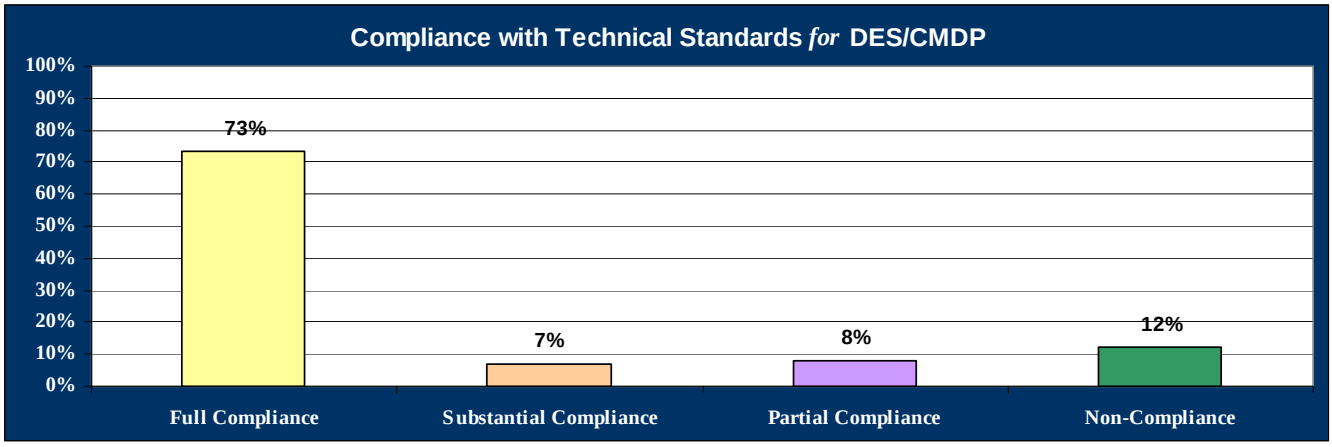
Opportunities for improvement exist wherever performance is not perfect. Nonetheless, these opportunities must be prioritized to make the best use of limited resources. For this reason, there are no specific opportunities for improvement or recommendations provided for University's PIPs.

Department of Economic Security Comprehensive Medical and Dental Program (DES/CMDP)

Compliance with Standards (Operational and Financial Review)

Figure 3-27 shows the DES/CMDP percentage of compliance with the technical standards selected for review in CY 2005–2006. The percentages of the standards in Full Compliance, Substantial Compliance, Partial Compliance, and Non-Compliance are shown separately.

Figure 3-27—Compliance with Technical Standards *for* DES/CMDP



When interpreting the information in Figure 3-27, the difference between at least Partial Compliance and Full Compliance reflects a scenario in which the health plan seems to know the intent of the technical standards but is not fully achieving compliance. This scenario contrasts with Non-Compliance, which indicates that the health plan might not understand the intent of the technical standards. In the first case (i.e., understanding but not fully achieving compliance with the technical standards), the health plan might make large strides in attaining Full Compliance with relatively little effort. Moving a technical standard from Non-Compliance to Full Compliance, however, might require technical assistance and other activities, such as those delineated in the section on opportunities for improvement and recommendations. The health plan's Non-Compliance rate of 12 percent was substantively higher than the statewide average of 9 percent. Substantially and partially compliant standards were 7 percent and 8 percent, respectively, of the total number of standards across the nine categories reviewed.

This overall pattern of results can obscure both strengths and opportunities for improvement for specific categories of standards. Figure 3-28 shows the extent of compliance for each of the major areas within the technical standards. The figure highlights areas of strength and areas with opportunities for improvement. In each category, the figure shows the level of compliance with the technical standards based on Full Compliance, Substantial Compliance, Partial Compliance, and Non-Compliance.

Figure 3-28—Categorized Levels of Compliance with Technical Standards *for* DES/CMDP

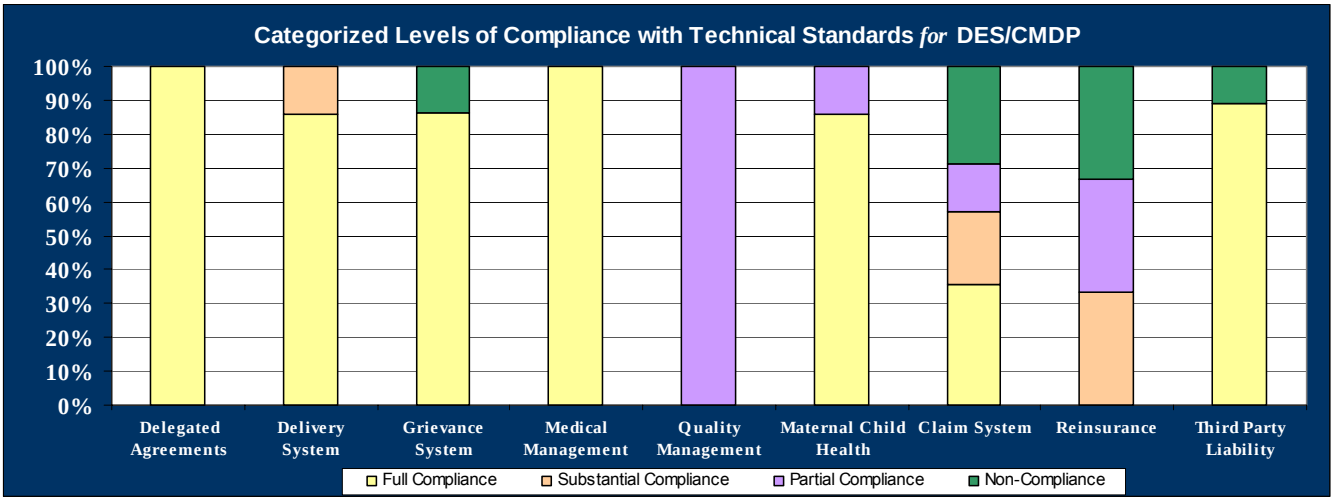


Figure 3-28 shows that the technical standards associated with Delegated Agreements and Medical Management were all in Full Compliance with requirements. The figure also shows the importance of comparing information presented in this format with similar information presented in the format shown in Table 3-20. The partially compliant standards, which constitute 8 percent of all scored technical standards, appear in Figure 3-28 to be mostly in the Quality Management category. Yet, Table 3-20 shows that Quality Management had only two scored standards. Six standards, in total, were scored as Partially Compliant for the health plan, including two in Claims System and one each in Maternal and Child Health and in Reinsurance. Nonetheless, Figure 3-28 shows opportunities for improvement within the Quality Management, Claims System, and Reinsurance technical standards.

CAPs for Compliance with Standards

Table 3-20 shows each of the categories of technical standards reviewed, the number of CAPs required, the percentage of CAPs in each category, the number of technical standards in each category, and the percentage of technical standards for each category with a required CAP.

Table 3-20—CAP Overview *for* DES/CMDP				
Categories of Technical Standards	Number of CAPs	Percent of Total CAPs	Total Number of Standards	CAPs as a Percent of Standards
Delegated Agreements	0	0%	6	0%
Delivery System	1	5%	7	14%
Grievance System	5	26%	22	23%
Medical Management	0	0%	5	0%
Quality Management	2	11%	2	100%
Maternal and Child Health	1	5%	7	14%
Claims System	6	32%	14	43%
Reinsurance	3	16%	3	100%
Third Party Liability	1	5%	9	11%
Total	**19**	**100%**	**75**	**25%**

In addition to showing no required CAPs associated with Delegated Agreements and Medical Management, Table 3-20 shows Grievance, Quality Management, Claims System, and Reinsurance as all having more than one associated CAP. All five of the standards that were associated with Quality Management and Reinsurance were required to have a CAP.

Performance Measure Review

Table 3-21 shows the separate performance measures for the two most recent time periods, along with the statistical significance for each of the changes in rates over time. Additionally, the table presents the minimum AHCCCS performance standards and whether a CAP was required.

Table 3-21—Performance Measurement Program *for* DES/CMDP			
Performance Measure	Previous Measurement Period[1]	Actual Performance for Oct. 1, 2004, to Sept. 30, 2005	Minimum AHCCCS Performance Standard
Children's Access to PCPs[2]	**86.8%**	**88.0%**	79%
Adult's Access to Preventive/Ambulatory Health Services[2]	N/A	N/A	80%
Breast Cancer Screening[2,3]	N/A	N/A	57%
Cervical Cancer Screening[2,4]	N/A	N/A	61%
Timeliness of Prenatal Care[4]	N/A	N/A	62%
Childhood Immunization—4 DTaP	78.0%	(76.6%)	83%
Childhood Immunization—3 IPV	**92.0%**	(87.6%)	89%
Childhood Immunization—1 MMR	**94.0%**	**(91.0%)**	90%
Childhood Immunization—3 HiB	**83.0%**	(73.2%)*	76%
Childhood Immunization—3 HBV	**83.5%**	(77.3%)	82%
Childhood Immunization—1 VZV	**85.0%**	**86.0%**	77%
Childhood Immunization—DTP, IPV, & MMR (4:3:1 Series)	74.0%	(71.9%)	80%
Childhood Immunization—DTP, IPV, MMR, HIB, & HBV (4:3:1:3:3 Series)	61.0%	(53.2%)	70%

Notes:
Bolded rates exceed the minimum AHCCCS performance standard.
Nonbolded rates in the current measurement cycle require a CAP.
() Parentheses for current performance indicate a decrease from the previous measurement cycle.

* Statistically significant change from the previous measurement period at $p \leq .05$.

N/A is Not Applicable due to membership restrictions.

[1] Children's Access to PCPs and Adult's Access to Preventive/Ambulatory Health Services performance measures are measured and reported annually. All other performance measures are measured and reported on a rotating basis to allow health plans an intervention year between reporting periods.

[2] AHCCCS changed the methodology for collecting data and used a data warehouse to gather rate information. In order to have valid comparisons with data collected using the new process, AHCCCS used the data warehouse to recalculate rates for the previous year using the current methodology. Therefore, the rates in this report cannot be directly compared with the rates detailed in the 2006 EQRO report.

[3] The previous remeasurement period for Breast Cancer Screening was Oct. 1, 2002, through Sept. 30, 2004. The current measurement period is Oct. 1, 2003, through Sept. 30, 2005.

[4] The previous remeasurement period for Cervical Cancer Screening and Timeliness of Prenatal Care was Oct. 1, 2003, through Sept. 30, 2004.

The bolded rates show that the plan exceeded the minimum AHCCCS performance standards for just three of nine assessed measures,[3-8] leaving six nonbolded rates that require CAPs. Further, all but two of the rates declined between measurement periods, although only the rate for childhood Immunization—3 HiB declined by a statistically significant amount (i.e., $p \leq .05$). Three of the

[3-8] Four of the measures were not applicable due to membership restrictions (i.e., only children).

declining rates that had exceeded the minimum AHCCCS performance standard during the previous measurement period, did not meet the minimum standard during the most recent measurement period.

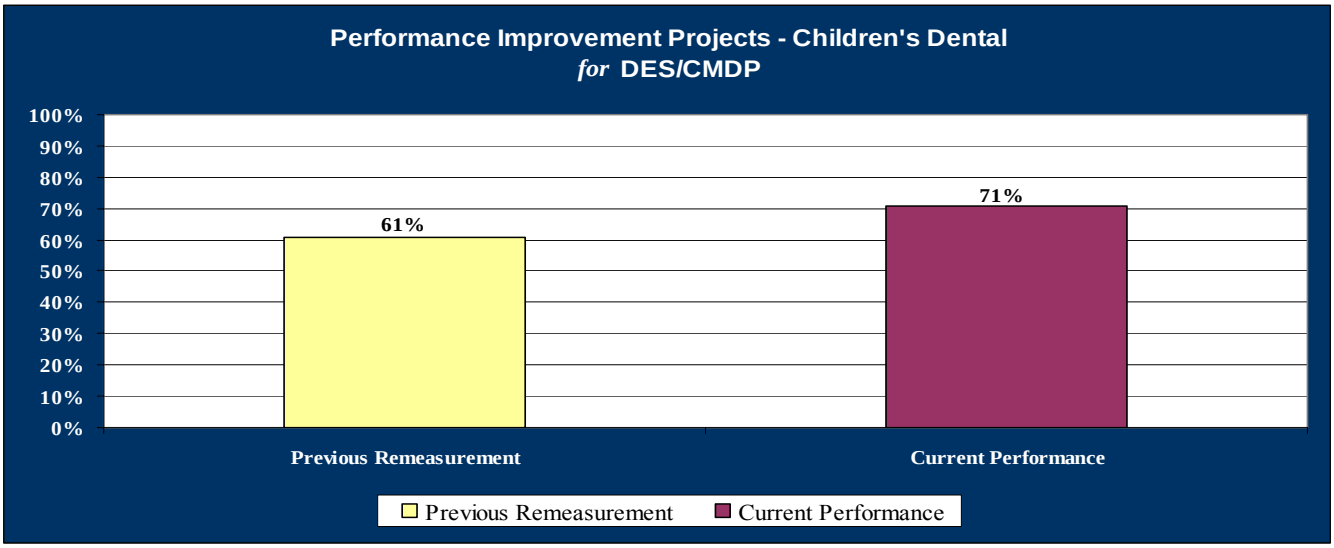
Performance Measures—CAPs

Table 3-21 shows that six of the nine performance measures required a CAP by not reaching the minimum AHCCCS performance standards. The six measures requiring a CAP were all measures of childhood immunizations. A comparison with the previous measurement period shows that for the measures of childhood immunization, the number of measures with rates that met or exceeded the minimum AHCCCS performance standards fell from five of the eight measures in the previous measurement period to two of the eight in the current period.

Review of PIPs

Figure 3-29 presents the results from the Children's Dental PIP. The results show that the plan substantially improved its previous rate, by 10 percentage points. The plan's performance is commendable, especially compared with the next highest rate for a health plan of 62 percent.

Figure 3-29—PIP Results *for* DES/CMDP



The plan reported multiple ongoing interventions to improve PIP outcomes related to Children's Dental. These interventions included: dental reminder postcards, follow-up phone calls and mailings by the case manager for children continuously enrolled who had not received a dental visit, distribution of educational materials through newsletter articles, Child Protective Services (CPS) site visits, conferences and ongoing case management activities, articles in DES/CMDP News, presentations at pediatric conferences, and establishing dental health as a priority in the child welfare system. DES/CMDP reported that these interventions directly contributed to the significant increase from CYE 2002 to 2004 in the percentage of children receiving dental care.

Strengths, Opportunities for Improvement, and Recommendations for DES/CMDP

The next three sections discuss: (1) compliance with standards, (2) performance measures, and (3) PIPs. Each of these three sections presents the strengths found in the documentation provided to HSAG, opportunities for improvement, and recommendations.

Compliance with Standards (Operational and Financial Review)

Strengths

The health plan was in Full Compliance with all of the technical standards associated with Delegated Agreements and Medical Management, making these areas of recognized strength. Overall, however, the plan had about the same pattern of compliance with standards as was seen on average statewide. This finding was evidenced by 25 percent of the plan's standards requiring a CAP compared with 26 percent statewide.

Opportunities for Improvement and Recommendations

Opportunities for improvement were shown to aggregate within the technical standards associated with Grievance System, Quality Management, Claims System, and Reinsurance.

For the Grievance System, the current review included 22 standards covering several aspects of grievance processing and reporting. Appropriate grievance systems can be an important source of information about areas of need for quality improvement activities, and appropriately structured and responsive grievance systems can markedly improve member satisfaction. Grievance systems are also important for transparency, which is fundamental to timely access to quality care, as well as to quality improvement.

Recommendation: The plan should consider initiating a comprehensive evaluation of its grievance system structure and processes that could include flow-charting both current and ideal processes to identify areas of performance vulnerability and opportunities for strengthening both performance and checks-and-balances systems of monitoring. Ideally, the evaluation would identify the factors that are contributing to the failure to fully comply with requirements (i.e., incomplete or unclear policies and procedures, staff performance such as failure to perform required actions within required time frames or failure to document the actions, and failure of the plan to conduct sufficiently detailed and frequent monitoring, etc.). The plan should also consider identifying opportunities to increasingly automate systems for logging and tracking information and actions related to the processing of grievances. For example, Technical Standard GS5 states: "The Health Plan provides the member written notice of the reason for the decision to extend the timeframe." This standard examines standing policy and the methods implemented for complying with the requirement. The standard was in Non-Compliance. This would be an excellent opportunity for the plan to automate logging and tracking of the timelines and required actions (i.e., sending a notice requesting an extension that includes the reason) and for auto-generating the notices with the reason for the extension built in as a required field, if these processes are not already in place. The plan may want to prioritize those improvements that can be most easily addressed and implemented through converting, when feasible, from manual to automated processes for conducting required actions (i.e., auto-generation of required notices) and for documenting/logging/tracking, etc.

There were only two assessed standards within Quality Management for the plan.[3-9] Both standards were in Partial Compliance.

Recommendation: The plan should consider a coordinated approach between its quality management staff/committee and the individuals responsible for managing and oversight of the grievance procedures to resolve related issues in a manner that capitalizes on the interdepartmental nature of the two categories of standards (i.e., Grievance System and Quality Management).

Six of the technical standards within Claims System required a CAP.

Recommendation: Given the number of standards requiring corrective action, the plan should consider convening a time-limited work group charged with conducting an analysis of the barriers to compliance and developing recommended revisions or enhancements to the policies, procedures, and practices to ensure that they are written, designed, and implemented in a way that ensures the plan's compliance with AHCCCS and other applicable binding requirements. Many of the standards that were in less than Full Compliance related to the timing of various types of claims and their associated policies and procedures, which suggested that a comprehensive and detailed review of the plan's policies and operating procedures compared with the AHCCCS and other binding requirements would be the first, and perhaps the only, corrective action required to bring the plan into Full Compliance.

Reinsurance has been shown to be a statewide opportunity for improvement, and DES/CMDP is not excluded from that finding, with all of its three standards in this category requiring a CAP. As previously shown, the State regulations appear to be sufficiently clear for the plan to easily align its policies and procedures with the State's to ensure that the processes are in place for properly addressing reinsurance requirements. The creation of fully compliant policies and procedures related to processing of encounter information, especially for reinsurance, involves a comparison of current information to the State's requirements.

Recommendation: The plan should consider conducting a rigorous review of its reinsurance policies and procedures to ensure that they are consistent with and address all the requirements as specified by AHCCCS and any other applicable binding regulations.

Performance Measure Review

Strengths

The three performance measures that exceeded the minimum AHCCCS performance standards were recognized strengths. These measures were: Children's Access to PCPs and Childhood Immunizations—1 MMR and 1 VZV.

Opportunities for Improvement and Recommendations

There were six performance measures with rates below the minimum AHCCCS performance standards, all of which were measures of childhood immunizations and required CAPs. DES/CMDP

[3-9] QM2: The health plan has a process for reviewing and evaluating quality of care complaints and allegations, and QM3: The health plan resolves quality-of-care/service issues raised by enrolled members and contracted providers.

is limited in the extent to which it has access to prior health care records, including the history of immunizations received, for those children entering foster care. This lack of complete and accurate information would be expected to negatively impact the performance rates for childhood immunizations and represents an ongoing barrier over which DES/CMDP has very limited control.

In addition, improving childhood immunization is often accomplished through strategies that improve access while reminding both physicians and members of the need and benefit of immunizations, when appropriate. Yet, the rate for the Children's Access to PCPs measure of 88 percent suggests that access may not be as much of an issue as the lack of physician and/or member reminder systems or other barriers.

Recommendation: If not already operational, the health plan should consider implementing or enhancing current physician and/or member reminder systems as one method for positively impacting the plan's performance measure rates associated with childhood immunizations. Implementing automated reminder services could reduce the burden of less efficient and more manual methods and increase the probability that all reminders are delivered when immunizations are due.

Review of PIPS

Strengths

The results for the Children's Dental PIP were the best in the State, reflecting a definite strength for the plan.

Opportunities for Improvement and Recommendations

Given the exceptional results from the Children's Dental PIP, no opportunities for improvement or recommendations are offered for the DES/CMDP PIP.

Compliance with Standards (Operational and Financial Review)

Figure 4-1 depicts the rates for Full Compliance with the technical standards for all health plans. The figure shows that the rates of Full Compliance varied from 63 percent for APIPA to 89 percent for Pima, a range of 26 percentage points.

Figure 4-1—Full Compliance Comparison *for* All Health Plans

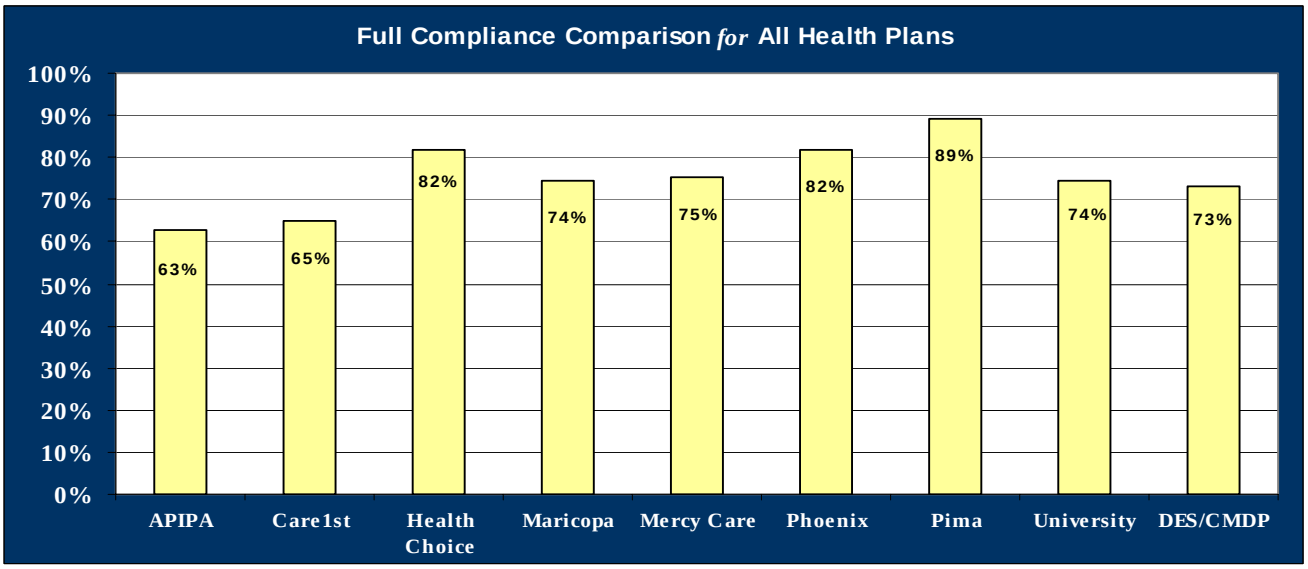
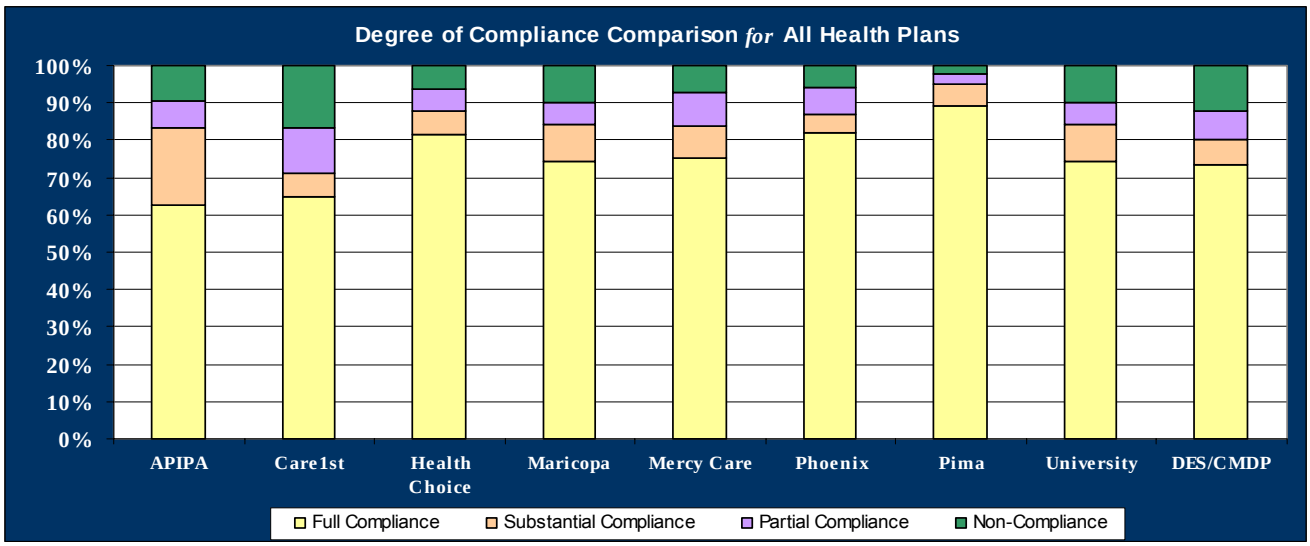


Figure 4-2 shows the extent to which each health plan was in Full Compliance, Substantial Compliance, Partial Compliance, and Non-Compliance for the technical standards reviewed in each of the nine categories.

Figure 4-2—Degree of Compliance Comparison for All Health Plans



While Figure 4-2 also displays the information depicted in Figure 4-1, it also highlights that the largest proportion of standards in Non-Compliance was from Care1st and the smallest proportion was from Pima. The figure shows the largest proportion of standards in Partial Compliance was, again, from Care1st, and the smallest proportion was, again, from Pima. The highest proportion of standards scored in Substantial Compliance was found for APIPA and the lowest was found for Phoenix.

CAPs for Compliance with Standards

Table 4-1 presents the number of CAPs for each of the categories of technical standards, the total number of CAPs for each of the health plans, and the percentage of each plan's assessed technical standards that required a CAP.

Table 4-1—CAP Overview *for* All Plans Individually									
Category	APIPA	Care1st	Health Choice	Maricopa	Mercy Care	Phoenix	Pima	University	DES/ CMDP
Delegated Agreements	1	2	1	2	2	2	0	2	0
Delivery System	1	3	0	0	1	0	0	0	1
Grievance System	12	7	10	7	7	2	0	7	5
Medical Management	2	3	1	0	1	0	2	0	0
Quality Management	3	1	0	2	0	1	0	2	2
Maternal and Child Health	4	3	0	3	1	4	0	3	1
Claims System	4	5	2	4	4	4	1	5	6
Reinsurance	3	4	1	2	3	4	4	2	3
Third-Party Liability	2	1	0	3	3	1	1	3	1
Total†	**32**	**29**	**15**	**23**	**22**	**18**	**8**	**24**	**19**
Percent CAPs	**39%**	**35%**	**18%**	**28%**	**27%**	**22%**	**10%**	**29%**	**25%**

† Differences in total number of CAPs need to be interpreted with caution, due to the different numbers of standards for which each plan is responsible. The Percent CAPs figures adjust for these differences and can be validly compared across health plans.

The table shows that the percentage of assessed technical standards that required a CAP varied from a low of 10 percent at Pima to a high of 39 percent at APIPA, with a statewide rate of 26 percent.[4-1] The range of 29 percentage points across health plans is quite large and suggests that most of the plans would benefit from strategically focused, short-term task forces or committees charged with aligning their policies and procedures with the AHCCCS requirements and other activities as specifically described for each plan in Section 3 (Plan-Specific Findings) related to each of the technical standards that required a CAP. At least one of the plans was scored in Full Compliance with every standard in seven of the nine categories in Table 4-1. Every technical standard within the other two categories was scored in full compliance for at least one of the health plans.

It can be a time-consuming task for plans to bring the documentation for policies and procedures that describe the plans' processes up to Full Compliance in addressing all applicable AHCCCS requirements. Nonetheless, processes cannot be improved or even controlled until the appropriate descriptive and performance documentation is in place. Health plans exceeding the statewide average rate of 26 percent CAPs were encouraged to consider conducting comprehensive, robust reviews of systems in areas where performance was particularly challenging, including a review of policies and procedures and other key aspects of the plan's operations. These plans included APIPA, Care1st, Maricopa,[4-2] Mercy Care, and University. Once policies and procedures are brought into alignment with all the AHCCCS requirements, it will be equally important for the plans to: (1) determine if they have sufficient processes and procedures in place to ensure that all applicable staff, providers, delegates, etc. are fully informed about and, as applicable, trained on the policies and procedures; (2) frequently and comprehensively monitor performance in complying with the policies and procedures; and (3) when indicated by the monitoring processes, implement immediate corrective actions.

[4-1] Shown in Table 3-1.

[4-2] This recommendation may no longer be applicable in light of the change in management at Maricopa.

Performance Measure Review

Table 4-2 presents the rates for all of the performance measures for the current review cycle and the minimum required AHCCCS performance standards. Where a cell lists N/A (Not Applicable), the health plan was not required to report the performance measure. As seen in the table, this only applies to rates for DES/CMDP where the measures for adult members were not applicable as DES/CMDP does not provide services to adult members.

Table 4-2—Most Recent Performance Measures *for* All Plans Individually

Category	APIPA	Care1st	Health Choice	Maricopa	Mercy Care	Phoenix	Pima	Univ	DES/ CMDP	Minimum AHCCCS Perfor-mance Standard
Child Access to PCPs	78.0%*	77.7%*	76.9%	69.3%*	78.8%*	77.2%*	**81.7%**	**81.2%**	**88.0%**	79%
Adult Prev/Amb Care	**80.4%***	73.5%*	77.9%	74.2%	**80.2%**	77.9%	78.2%	**(80.1%)**	N/A	80%
Breast Cancer Screen	51.4%*	36.1%	42.2%	(50.2%)	(47.3%)	46.9%*	(54.6%)	(51.7%)	N/A	57%
Cerv. Cancer Screen	58.6%*	48.8%*	57.4%*	55.8%*	57.7%	(27.4%)*	57.3%*	(59.1%)	N/A	61%
Timely Prenat Care	**(63.3%)***	59.3%*	**(62.3%)**	61.4%	**(70.3%)***	(56.3%)	(59.3%)	**68.3%**	N/A	62%
Child Imm—4 DTP	**84.5%***	74.1%	82.6%*	**(84.6%)**	**(84.3%)**	**(83.3%)**	**94.4%**	**87.4%***	(76.6%)	83%
Child Imm—3 IPV	**93.6%***	**89.8%**	**93.0%***	**(95.6%)**	**(91.4%)**	**(92.6%)**	**98.3%***	**94.9%**	(87.6%)	89%
Child Imm—1 MMR	**93.8%***	89.8%	**92.1%**	**(93.9%)**	**(93.4%)**	**(94.1%)**	**97.8%**	**96.0%**	**(91.0%)**	90%
Child Imm—3 HiB	**87.6%***	**84.3%**	(74.3%)*	**(88.6%)**	**88.2%**	**(87.7%)**	**96.1%**	**89.1%**	(73.2%)*	76%
Child Imm—3 HBV	**92.3%***	**86.1%**	**87.0%***	**(84.6%)***	**90.1%**	**(88.5%)**	**93.1%**	**92.6%**	(77.3%)	82%
Child Imm—1 VZV	**86.0%***	**80.7%**	**(81.8%)**	**(89.9%)**	**87.9%***	**(85.3%)**	**95.7%**	**86.9%**	**86.0%**	77%
Child Imm—DTP, IPV, & MMR (4:3:1)	**83.0%***	72.3%	**80.4%***	**(84.6%)**	**82.8%**	**(81.1%)**	**92.6%***	**85.1%***	(71.9%)	80%
Child Imm—DTP, IPV, MMR, HIB, & HBV (4:3:1:3:3)	**76.4%***	66.3%	62.1%*	**(72.8%)**	**76.2%**	**(74.4%)***	**84.4%**	**76.6%**	(53.2%)	70%
Average of Existing Measures	**79.1%**	72.2%	74.6%	**(77.3%)**	**79.1%**	(74.8%)	**83.3%**	**80.7%**	**(78.3%)** †	**75.8%**

Bolded rates exceed the minimum AHCCCS performance standard.

Nonbolded rates in the current measurement cycle require a CAP.

() Parentheses for current performance indicate a decrease from the previous measurement cycle.

* Statistically significant change from the previous measurement period at $p \leq .05$. The changes in the plans average rates between measurement cycles were not tested for statistical significance, as the large numbers and lack of independence for the cases across the measures limits the interpretability of statistical tests,

N/A is Not Applicable

† NA is indicated for DES/CMDP for the four performance measures related to adults, as DES/CMDP does not provide services to adults. Therefore, the average of existing measures was calculated on four fewer required measures for DES/CMDP than for the other plans.

From an overall perspective, the table shows the highest average rate from Pima, at 83.3 percent, and the lowest from Care1st, at 72.2 percent. The average rate across five of the eight plans with thirteen measures (i.e., DES/CMDP was excluded from this comparison because it had fewer measures) exceeded the minimum AHCCCS performance standards, although the average rate from Maricopa showed a decline in performance from the previous measurement period.

Table 4-2 presents additional information in a plan-comparison format. This information includes four important aspects of an assessment of quality improvement for the reviewed performance measures. First, measures with bolded rates have exceeded the minimum AHCCCS performance standards. Second, nonbolded rates in the current measurement period have a required CAP. Third, rates in the current measurement periods that are within parentheses indicate a decline in performance between the two measurement periods displayed, whereas rates without parentheses indicate a stable or increasing rate. Fourth, statistically significant change is indicated by an asterisk (*).[4-3]

For the first of these aspects (i.e., rates exceeding the minimum AHCCCS performance standards), the table shows that all of the health plans were successful for only one measure (i.e., Child Immunization—1 VZV). Three childhood immunization measures showed rates exceeding the minimum AHCCCS performance standards by all but one health plan (i.e., Child Immunizations—3 IPV, 1 MMR, and 3 HBV). These immunization measures were also recognized strengths across health plans.

The second of the assessment aspects (i.e., nonbolded rates requiring a CAP) shows that every health plan, statewide, was required to have CAPs for the Breast and Cervical Cancer Screening performance measures. The minimum AHCCCS performance rates were reasonable targets, from a national performance perspective. The Breast Cancer Screening minimum standard of 57 percent was between the 50th and 75th national Medicaid HEDIS® percentile rates of 54.7 percent and 59.4 percent, respectively. The minimum standard of 61 percent for Cervical Cancer Screening was between the 25th and 50th national Medicaid HEDIS® percentile rates of 58.6 percent and 64.5 percent, respectively. All of the other performance measures had at least three health plans with rates that exceeded the minimum AHCCCS performance standards.

For the third aspect of the assessment (i.e., direction of change in rates), Table 4-2 appears to show that Care1st was the only health plan with all increasing rates. Although technically accurate, Care1st had only four rates with comparable information from the previous measurement period, indicating that nine of its rates could not have gone up or down. From the perspective of improving rates on the selected performance measures, APIPA had the strongest performance by improving all but one rate, followed by Pima, with improvement in all but two rates, and by Health Choice and University, with improvement in all but three rates. Conversely, the average rate for Maricopa, Phoenix, and DES/CMDP declined between the two most recent measurement periods.

The fourth aspect of the assessment (i.e., statistically significant change) is often interpreted as an outcome of effective quality improvement efforts when it is in the positive direction, and as evidence of a high-priority opportunity for improvement when it is in the direction of declining rates. APIPA clearly showed the largest number of performance measures with rates that changed

[4-3] Statistical significance testing is only done on the individual measures due to methodological issues testing the aggregate. Nonetheless, the sizes of the aggregate groups would almost always yield highly significant differences ($p < .001$).

by a statistically significant amount, and all but one of those changes were in the direction of improvement. The one measure that statistically decreased was still above the minimum AHCCCS performance standard.

Performance Measures—CAP

Table 4-3 presents the CAPs for each performance measure for each health plan with the total number of CAPs required. N/A signifies a performance measure that was not required to be reported by the health plan. This only applies to DES/CMDP for the four adults measures as DES/CMDP does not provide services to adults. All other health plans were required to report the full measure set.

Table 4-3—CAPs for Performance Measures *for* All Plans Individually

Category	APIPA	Care1st	Health Choice	Maricopa	Mercy Care	Phoenix	Pima	Univ	DES/ CMDP	Total CAPs
Child Access to PCPs	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	6
Adult Prev/Amb Care	No	Yes	Yes	Yes	No	Yes	Yes	No	N/A	5†
Breast Cancer Screen	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	N/A	8†
Cerv. Cancer Screen	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	N/A	8†
Timely Prenat Care	No	Yes	No	Yes	No	Yes	Yes	No	N/A	4†
Child Imm—4 DTP	No	Yes	Yes	No	No	No	No	No	Yes	3
Child Imm—3 IPV	No	No	No	No	No	No	No	No	Yes	1
Child Imm—1 MMR	No	Yes	No	No	No	No	No	No	No	1
Child Imm—3 HiB	No	No	Yes	No	No	No	No	No	Yes	2
Child Imm—3 HBV	No	No	No	No	No	No	No	No	Yes	1
Child Imm—1 VZV	No	No	No	No	No	No	No	No	No	0
Child Imm—DTP, IPV, & MMR (4:3:1)	No	Yes	No	No	No	No	No	No	Yes	2
Child Imm—DTP, IPV, MMR, HIB, & HBV (4:3:1:3:3)	No	Yes	Yes	No	No	No	No	No	Yes	3
Total CAPs per Plan	**3**	**9**	**7**	**5**	**3**	**5**	**4**	**2**	**6†**	**44**

N/A is Not Applicable.

† Differences for these totals need to be interpreted in light of the fact that there were four fewer required measures (i.e., the measures related to performance for adults) for DES/CMDP as the plan does not provide services to adults.

Table 4-3 shows that University had fewer CAPs for the performance measures than any other plan, followed by APIPA and Mercy Care. Care1st had the largest number of CAPs, followed by Health Choice. Plans averaged about five CAPs each.

Childhood Immunization—1 VZV was the only measure to not have a required CAP for any of the nine health plans. Further, only one of the nine plans was required to have a CAP for Childhood Immunizations—3 IPV, 1 MMR, or 3 HBV. These performance measures clearly outperformed those that required more CAPs, as briefly discussed below.

As was noted previously, all of the health plans reporting the measures for Breast and Cervical Cancer Screening were required to have a CAP for each measure. Six of the nine plans were required to have a CAP for Childhood Access to PCPs. Recommendations for these and other opportunities for improvement were provided for the impacted health plans in Section 3 of this report.

Review of Performance Improvement Projects

Table 4-4 presents the results for each of the health plans' HbA1c testing measure for the two most recent measurement periods. The last measurement for the Diabetes Management PIP was conducted to show sustained improvement (i.e., no statistically significant decline/worsening in rates). Five of the seven health plans with comparative rates saw their rates not only sustain, but also increase. The results show that the overall average rate across the health plans improved somewhat, from 79.2 percent to 80.7 percent and was between the 50th and the 75th national HEDIS® Medicaid 2005 percentile rates of 78.4 percent and 84.1 percent, respectively. Overall, only two of the seven health plans with documentation for an adult diabetes management PIP had rates that were below the median national rate (i.e., below 78.4 percent).

Table 4-4—Performance Improvement Projects—HbA1c Testing *for* All Health Plans

Health Plan	Oct. 1, 2002–Sept. 30, 2003	Oct. 1, 2003–Sept. 30, 2004	Relative Change	Significance Level
Arizona Physicians IPA	82.5%	85.2%	3.3%	p=.323
Care1st	N/A[1]	N/A[1]	N/A[1]	N/A[1]
Health Choice of Arizona	83.2%	85.5%	2.8%	p=.436
Maricopa Health Plan	83.6%	81.2%	-2.9%	p=.452
Mercy Care Plan	78.8%	83.0%	5.3%	p=.154
Phoenix Health Plan	65.4%	66.9%	2.3%	p=.693
Pima Health System	80.3%	77.0%	-4.2%	p=.373
University Family Care	81.5%	85.9%	5.4%	p=.214
DES/CMDP	N/A[2]	N/A[2]	N/A[2]	N/A[2]
Average	**79.2%**	**80.7%**	**1.9**	**p=.220**

[1] Care1st was not a participating health plan at the time of this PIP.

[2] DES/CMDP did not participate in this PIP.

Statistically significant change from the previous measurement period was p ≤ .05.

Table 4-5 presents the results for each of the health plans' HbA1c poor control measure for the two most recent measurement periods. Having adjusted for the reversed nature of the measure, the table shows improvement was not only sustained, but rates also improved for six of the seven plans that were required to report for this measure of diabetes management. Health Choice distinguished itself by not only sustaining performance, but also having statistically significant improvement in performance between the two measurement cycles. When aggregated to the statewide level, the average rate for the measure also improved between measurement periods by a statistically significant amount (p = .002). The statewide rate of 33.0 percent is between the 75th and 90th national HEDIS® Medicaid percentile rates of 37.8 percent and 31.1 percent, respectively.

Table 4-5—Performance Improvement Projects—HbA1c Poor Control *for* All Health Plans				
Health Plan	**Oct. 1, 2002–Sept. 30, 2003**	**Oct. 1, 2003–Sept. 30, 2004**	**Relative Change***	**Significance Level**
Arizona Physicians IPA	32.8%	27.3%	16.8%	p=.109
Care1st	N/A[1]	N/A[1]	N/A[1]	N/A[1]
Health Choice of Arizona	34.2%	25.7%	24.9%	p=.022
Maricopa Health Plan	38.3%	33.6%	12.3%	p=.254
Mercy Care Plan	32.6%	31.0%	4.9%	p=.657
Phoenix Health Plan	53.1%	46.5%	12.4%	p=.104
Pima Health System	37.2%	37.8%	-1.6%	p=.886
University Family Care	37.0%	31.2%	15.7%	p=.197
DES/CMDP	N/A[2]	N/A[2]	N/A[2]	N/A[2]
Total	**37.7%**	**33.0%**	**12.5**	**p=.002**

* The rates for relative change have had their signs reversed to accommodate the reversed structure of the measure where lower rates over time indicate improved care.

[1] Care1st was not a participating health plan at the time of this PIP.

[2] DES/CMDP did not participate in this PIP

Statistically significant change from the previous measurement period was p ≤ .05.

Table 4-6 shows the results for the Children's Dental PIP. The rate for only one health plan (i.e., Health Choice) decreased and by a statistically significant amount. Seven health plans saw their rates increase with the rates for five of the plans increasing by a statistically significant amount.

Table 4-6—Performance Improvement Projects—Children's Annual Dental Visits *for* All Health Plans					
Health Plan	Oct. 1, 2003–Sept. 1, 2004	Oct. 1, 2004–Sept. 1, 2005	Relative Change	Significance Level	Minimum AHCCCS Performance Standard
Arizona Physicians IPA	55.8%	60.5%	8.3%	p<.001	57.0%
Care1st	N/A[1]	N/A[1]	N/A[1]	N/A[1]	
Health Choice of Arizona	62.7%	58.4%	-6.8%	p<.001	
Maricopa Health Plan	42.1%	59.9%	42.2%	p<.001	
Mercy Care Plan	60.0%	61.8%	3.0%	p<.001	
Phoenix Health Plan	60.4%	61.3%	1.4%	p=.138	
Pima Health System	59.8%	61.0%	2.1%	p=.375	
University Family Care	57.8%	62.3%	7.8%	p=.005	
DES/CMDP*	61.0%	71.0%	16.3%	p<.001	
Total	**57.7%**	**60.9%**	**5.4%**	**p<.001**	

[1]Care1st was not a participating health plan at the time of this PIP.

[2]DES/CMDP did not participate in this PIP.

Statistically significant change from the previous measurement period at p ≤ .05.

Overall Strengths

Pima showed overall strengths for the review of compliance with standards. Figure 4-1 and Figure 4-2 and Table 4-1 all show Pima as having the highest proportion of its technical standards in Full Compliance, and with numerically and proportionately the fewest CAPs.

Depending on the criterion (e.g., highest average rate, optimal quality improvement profile, or fewest CAPs), Pima, APIPA, or University, respectively, had the best results from the performance measure review. The performance was a strength for the three health plans.

For the Diabetes Management PIP, the most recent measurement was to determine if the plans sustained improvement. For five of the seven plans reporting for the measure, rates for HbA1c testing were not only sustained, but also improved. For six of the seven plans reporting for the measure, rates for HbA1c poor control were also not only sustained but also improved.

Per AHCCCS' protocol for conducting PIPs, health plans are considered to have completed a PIP when they have sustained prior year improvement. Overall, with the levels of not only sustained but also still improving performance at the end of the final measurement cycle and the final rates being above the national averages, the adult diabetes PIP appeared to be a clear statewide strength.

Seven of the eight health plans reporting rates for the Children's Dental PIP showed improvement. All eight health plans showed rates above the minimum AHCCCS performance standard. The statewide average increased from 57.7 percent to 60.9 percent, a statistically significant amount.

Overall Opportunities for Improvement and Recommendations

Complying with requirements for the technical standards associated with the Grievance System, Claims, and Reinsurance categories was particularly challenging and resulted in a significant number of CAPS for the health plans statewide. Specific opportunities for improvement and recommendations for these categories have been delineated in the plan-specific findings in Section 3 of this report. Success in becoming fully compliant with requirements in these areas typically requires a combination of having:

- Policies and procedures that are current (and updated as external requirements and/or internal procedures change), specific, detailed, and comprehensive in addressing the plan-specific procedures and accountabilities for ensuring compliance with each AHCCCS requirement and, as applicable, other binding external requirements.
- Processes for ensuring that applicable staff, providers, delegates, etc. are informed about and, as needed, trained on the policies and procedures and all revisions to them.
- Automated and maximized the efficiencies and quality control capabilities afforded by moving from manual to automated processes and using other current, state-of-the-art electronic and other technologies.
- Comprehensive monitoring systems and processes to assess the degree to which the plan's ongoing performance is in full compliance with the policies and procedures.
- Rapid-response quality improvement processes for correcting any detected lapses in or significant failures to perform.
- Regularly conducted an organizational scan to assess the organizational and operational structures and infrastructures related to factors such as sufficiency, efficiencies, flow of information, etc. and made adjustments when indicated as a result of the assessments.

The plans not in compliance with the standards in the three most challenging areas, as noted above, should consider conducting a comprehensive and rigorous review of systems related to each of the three categories for which the plan was not in full compliance. At a minimum, the review should include the areas identified in items 1–6 above. The plans should also consider conducting one or more self audits prior to the next AHCCCS OFR as a measure of their success in implementing the required CAPs and bringing plan performance into compliance with the applicable standards.

For performance measures, Breast and Cervical Cancer Screening are the most notable opportunities for improvement across the health plans statewide. This assessment is supported by the finding that every health plan that was required to report the two measures was also required to have a CAP for both of the measures. The specific recommendations, which were delineated in Section 3, included improving access and convenience of the testing. Given the challenges experienced by all the plans assessed on these measures, the plans may want to consider convening and facilitating a time-limited work group of appropriate health plan representatives to: (1) identify those best practice activities that appear to have contributed to improved performance on the indicators and those that were tried but appeared to have little or not impact on performance, and (2) brainstorm and share ideas for additional interventions that could be implemented by individual plans or across the plans. In addition, the plans may want to consider engaging in a joint statewide multimedia campaign, championed at the highest levels, that might prove helpful in: (1) increasing public and member awareness of and education about the importance and effectiveness of the health

preventative health care screenings; and, (2) ideally, as a result of the campaign, improving the plans' performance rates. Ultimately, if continued efforts to improve performance are not successful, the plans that have not already done so may want to consider implementing provider incentives and/or withholds/sanctions for performance and member incentives for making and keeping appointments for the screenings.

With the diabetes PIP now complete, the final documentation suggests that plan performance for the diabetes PIP was a commendable area of strength and there are no statewide opportunities for improvement or recommendations offered for this PIP. Conversely, the Children's Dental PIP is ongoing because a limited number of the health plans have not yet demonstrated significant and sustained improvement. In general, however, the plans performed well on the PIP and there are no overarching statewide recommendations in addition to the limited number of plan-specific recommendations in Section 3.

Following AHCCCS' assessment of the health plan performance related to the three mandated activities (compliance with standards, performance measures, and PIPs) and review of the plan-specific and statewide results as described in this report, AHCCCS engaged the health plans in a workgroup to accomplish multiple system-wide improvements in performance related to the quality and timeliness of and access to care and services provided to Medicaid members. The workgroup focused on improvement strategies that included, but were not limited to those as recommended in the preceding description of overall opportunities for improvement and recommendations.